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Childbirth in Hungarian Obstetric Care:
Attitudes, Experiences, Inequalities

Doctoral School of Sociology and
Communication Science

Sociology Doctoral Programme

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Doctoral Dissertation

Orsolya Udvari

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1. INTRODUCTION

1.1. Research focus and central argument

Demographic landscapes in Europe have become a key terrain where social anxieties, political projects, and intimate life decisions intersect. Demographic ageing and changing fertility trends characterise much of the world (Cheng *et al.*, 2022), but they are particularly pronounced in Europe (Makay and Ökrös, 2024). In Hungary, for instance, the total fertility rate fell to a low of 1.23 in 2011, recovered to 1.61 by 2021, and has since declined again, reaching 1.31 in 2025 – well below the replacement level of 2.1 (KSH, 2026). Low fertility is not unique to Hungary but characterises the European Union, where the average has likewise remained well below replacement (Eurostat, 2025). The process of population change is usually surrounded by public discourse of panic and anxieties, often articulated through narratives about the “death of the nation”¹. Yet demographic anxieties are dominantly centred around fertility and reproductive issues, and not on other major dimensions such as ageing and issues of care (Melegh, 2026). When “demographic crisis” is reduced to the number of births, questions of quality and equitable access tend to remain secondary in public policy and political debates. These include the quality of life of children who are born, the conditions under which they come into the world, and the social organisation of care, despite their centrality to long-term social reproduction (Katona and Gábel, 2026).

At the same time, it is important to acknowledge that fertility trends are well-researched internationally (Bloom *et al.*, 2024; Fauser *et al.*, 2024), comparatively and also on national levels (Németh *et al.*, 2023; Spéder, 2019; Spéder *et al.*, 2023). Scholarship documents changing patterns of family formation, delayed childbearing, and cross-national differences in birth rates, often linking these to economic conditions, gender regimes and social norms, and welfare arrangements (Kapitány and Spéder, 2021; Tóth, 2012). This dissertation starts from

¹ Szűcs, A. (6th March, 2023). Rohamosan fogynak a magyar – és máshol is ez várható a világon, egy látványos kivétellel. *Világ gazdaság*.

<https://www.vg.hu/vilaggazdasag/2023/03/rohamosan-fogy-a-magyar-es-mashol-is-ez-varhato-a-vilagon-egy-latvanyos-kivetellel> (Accessed: 11 March 2026).

Pénzcentrum (2023) ‘Totális összeomlás érik a magyar nyugdíjrendszerben: meg vannak számlálva az idősök napjai’, *Pénzcentrum*, 22 February. Available at: <https://www.penzcentrum.hu/nyugdij/20230222/totalis-osszeomlas-erik-a-magyar-nyugdijrendszerben-meg-vannak-szamlalva-az-idosek-napjai-1134350> (Accessed: 11 March 2026).

Pálos, M. (2023) ‘Sosem csökkent még ilyen mértékben Magyarország népessége két népszámlálás között’, *Telex.hu* (G7), 18 February. Available at: <https://telex.hu/g7/adat/2023/02/18/sosem-csokkent-meg-ilyen-mertekben-magyarorszag-nepessege-ket-nepszamlalas-kozott> (Accessed: 11 March 2026).

Süle-Szigeti, B. (2023) ‘Tényleg nem lesz nyugdíjunk az előregedő társadalomban?’, *Bankmonitor*, 23 February (updated 27 February 2023). Available at: <https://bankmonitor.hu/mediatar/cikk/tenyleg-nem-lesz-nyugdijunk-az-eloregedo-tarsadalomban/> (Accessed: 11 March 2026).

the observation that demographic change is also a political and moralised field shaped by hierarchies and socio-political and ideological aims. Within this field, fertility trends and childbearing are not only measured and debated; they are also governed. This article-based dissertation, comprising three studies, examines how these processes play out in the specific field of childbirth in Hungary.

Welfare-state responses to demographic change are frequently organised through social policy. They often place a huge emphasis on questions specifically around fertility and birth rates. Hence, the dominance of pronatalist family policies, meaning the encouragement of as many births as possible, within social policies is something we can observe, and this is especially true in the Hungarian case. This shows similarities with other countries within the European region (Camiscioli, 2001; Hašková and Saxonberg, 2016; Rivkin-Fish, 2010; Szalma *et al.*, 2022; Murinkó and Szalma, 2022; Szikra and Autischer, 2025). In Hungary, this takes a particularly concentrated form. For instance, the so-called Budapest Demographic Summits² and the constant discourse of “family-friendly government” functioned not only as a slogan but as a normative framing of what demographic responsibility and the family itself should look like. Such framings contribute to a policy environment where fertility and childbearing become central objects of intervention, while other dimensions of demographic change receive less public and political attention.

Consequently, Hungarian family policy is not neutral: it distributes resources, recognition, and institutional support selectively, along lines of social status, ethnicity, gender, and family form (Szikra, 2018a, 2018b). These uneven dynamics are reinforced by the symbolic and political role assigned to it. In this sense, family policy also carries a (not too) hidden agenda: it operates as a tool of nation building, defining the moral boundaries of belonging and the imagined future of the nation (Fodor, 2022).

Hungarian scholarship has explored how demographic and national imaginaries become intertwined, for instance through the relationship between fertility intentions and national identity (Erát, 2025), through debates surrounding the governance of assisted reproduction (Bauer, 2022; Szalma and Pélyi, 2025), birth screenings and controls (Morvay *et al.*, 2014), or abortion (Dés and Les, 2024). In this sense, family policy participates in producing normative ideals of family, gender roles, and citizenship, while shaping access to resources and institutional responsiveness.

² Budapest Demographic Summit (2023) *V. Budapest Demographic Summit*. Available at: <https://budapestidemografiasucs2023.hu/en> (Accessed: 13 March 2026).

In this article-based dissertation, family policy is treated as one – highly visible – arena where demographic objectives and governance become institutionalised. To conceptualise these processes, this dissertation draws on the concept of reproductive governance (Morgan and Roberts, 2012), which describes the mechanisms from legislative controls and economic inducements to moral injunctions and ethical incitements, through which diverse actors produce, monitor, and control reproductive behaviour and population practices. The concept is developed more fully in [Chapter 2.1.1](#); here it is introduced to frame the dissertation's approach to policy and obstetric care as fields of governance. This dissertation uses this analytical tool for understanding how demographic projects become operationalised through institutions, practices, moral narratives, and differential access in the specific field of obstetric care and in the life event of childbirth where these dimensions appear in a condensed form, offering a particularly revealing site for close empirical examination.

At the same time, the governance of reproduction extends well beyond family policy. The field of reproductive procedures is also governed very strongly through access, and through mechanisms of encouraging versus discouraging. This includes the regulation of abortion, assisted reproduction, and adoption, among other domains of childbearing. Crucially, governance operates through stratification (Morgan and Roberts, 2012); hence, these processes must be examined through an intersectional perspective, because that is how we can understand different groups' different forms of involvement and exposure. In Hungary, this includes attention to racialised inequalities, for example, the situation of Roma women, as well as socio-economic differences that shape both formal access and lived experiences within institutions. Reproductive governance is therefore not only “top-down”; it is enacted and experienced in situated ways.

The dissertation focuses on childbirth as a particularly revealing site where demographic projects, policy instruments, and institutional realities meet. From this starting point, it foregrounds a central tension between macro-level demographic goals and micro-level experiences of care: how can a state strongly promote childbearing while the institutional conditions under which childbirth takes place remain fragmented, unequal, and at times disrespectful? This is not simply a rhetorical question. It points to a structural contradiction in contexts where childbirth is politically significant and symbolically tied to national futures, while the organisation of care does not necessarily reflect this significance.

Against this background, the dissertation examines how reproductive governance and social inequalities become visible in childbirth experiences, evaluations of obstetric care, and women's strategies of navigation in Hungary through three studies. Its main focus is on

experiences, satisfaction, attitudes, and access, and on how classed, educational, geographical, and racialised positions shape both exposure to care and the room for manoeuvre available within institutions. Empirically, it treats childbirth primarily as a social process shaped by institutional arrangements, informal practices, and stratified access.

The central argument of the dissertation is that inequalities around childbirth function not only through differential access to services or clinical resources, but also through patterned differences in recognition, communication, continuity, and control. They are also reflected in the unequal – and often invisible – work women must undertake to make care pathways workable (Bradby *et al.*, 2019). Depending on their social position, this may involve mobilising money, information, social relations, or (partial) exit from the public system. Read together, the three studies show how reproductive governance is enacted through the everyday organisation of obstetric care, and how women’s capacities to respond to institutional fragmentation are socially stratified.

Against this background, the dissertation addresses the following overarching research question: How are social inequalities experienced and navigated in Hungarian obstetric care? This overarching question is addressed through three studies, each approaching inequalities in childbirth care from a different analytical and methodological perspective.

The remainder of this chapter introduces the design and relationship of the three studies that constitute the core of the dissertation, clarifies the scope and limitations of the dissertation, and outlines its overall structure.

1.2. Dissertation design and relationship between the studies

This is an article-based dissertation comprising three studies with different but complementary designs. Its methodological and analytical logic moves from a broad international evidence base to population-level patterns in Hungary, and then to an in-depth qualitative examination of lived experiences. A shared concern connects the studies with how inequality becomes visible in childbirth care, but they address this problem at different levels and through different forms of evidence.

The first study ([Chapter 3](#)) is a scoping review that systematically maps international research on maternal experiences around childbirth and their relationship to socio-economic factors in OECD countries. It establishes the broader evidence base by identifying recurring associations between social position and experiences, as well as gaps in the existing literature. Since most of the included studies used quantitative methods, women’s narratives and the institutional mechanisms behind the observed associations remained less visible. The review

therefore provides both an international point of departure and a basis for the questions examined more closely in the Hungarian studies.

The second study ([Chapter 4](#)) turns to the Hungarian context through a nationally representative survey. One part of the analysis uses the broader adult sample, including respondents without childbirth-related experience, to examine socially shared perceptions of what is required for better obstetric care. The analysis of personal satisfaction is restricted to respondents with relevant experience, including mothers and fathers evaluating their partners' care. The study identifies how satisfaction and perceptions of care are associated with socio-demographic characteristics and with the role of informal payments. It therefore examines population-level patterns within the Hungarian institutional context against the broader inequalities identified in the review.

The third study ([Chapter 5](#)) moves from population-level patterns to lived experiences and processes of navigation. Drawing on 26 semi-structured interviews with Roma and non-Roma mothers from diverse social backgrounds, it examines how women navigate obstetric care in the post-2021 context through different forms of healthcare bricolage, referring to the combination of available formal, informal, and relational resources to address healthcare needs and constraints. It explores how women assemble public, private, informational, and relational resources in an attempt to secure predictability, continuity, and dignity, and how access to these strategies is shaped by financial resources, social networks, geography, and racialised credibility. Rather than evaluating the 2021 reform as a policy outcome, the study examines how women experienced and navigated obstetric care within the institutional context reconfigured during this period.

The relationship among the studies is therefore analytical rather than simply thematic: the first maps recurring inequalities and gaps in knowledge; the second identifies Hungarian patterns and associations; and the third examines the mechanisms and strategies through which unequal care is anticipated and managed. Reproductive governance connects demographic and policy aims to the institutional organisation of childbirth; intersectionality directs attention to unequal exposure, recognition, and room for manoeuvre; and healthcare bricolage captures the practical work through which women attempt to make care workable. The final discussion brings these levels and analytical lenses into dialogue.

1.3. Scope and limitations

This dissertation examines childbirth primarily as a social process, with particular attention to inequalities, women's experiences of care, and the strategies through which they attempt to

navigate the Hungarian obstetric system. Its scope is therefore deliberately selective. It does not offer a comprehensive evaluation of Hungarian obstetric care, nor does it assess clinical quality, medical outcomes, or the appropriateness of particular interventions. Rather, it focuses on how care is experienced and interpreted, how institutional arrangements shape these experiences, and how women's room for manoeuvre differs across social positions.

The dissertation primarily examines women's experiences of obstetric care, while the survey study also analyses broader public perceptions on the care system and includes fathers' evaluations of their partners' experiences. Expert interviews and existing research are used to contextualise the institutional setting, but formal healthcare professionals were not included through a systematic sampling strategy, and their perspectives are not analysed as a separate empirical component. Relatedly, the chapter presenting the Hungarian context is deliberately interpretive rather than purely descriptive: it synthesises expert accounts and existing research into an analytical reading of the institutional setting that prepares the ground for the empirical chapters. The experiences of partners and other family members otherwise appear only indirectly. Furthermore, while the dissertation applies an intersectional perspective, its empirical focus falls mainly on socio-economic position, education, place of residence, and the racialisation of Roma women. Other potentially relevant dimensions, such as age, religion, or different family forms, could not be examined with the same depth.

The article-based format also has consequences for the integration of the dissertation. The three studies were developed independently, with different questions, methods, samples, and temporal perspectives, but under the doctoral research project carried out between 2021 and 2026. However, they were not designed as sequential components of a single mixed-methods study and are therefore not presented as a conventional form of mixed-methods triangulation. Instead, they provide complementary perspectives: the first maps the international literature, the second identifies population-level patterns and associations in Hungary, and the third examines lived experiences in greater depth. Their integration takes place at the level of the dissertation, through the shared concern with inequality, reproductive governance, and the institutional conditions of childbirth.

The studies also approach obstetric care through related but not interchangeable concepts. Childbirth experience, satisfaction, perceived quality of care, and healthcare bricolage refer to different dimensions of the relationship between women and obstetric care. Satisfaction is treated here as a subjective evaluation shaped not only by care itself, but also by expectations, social norms, earlier experiences, and retrospective interpretation. It should therefore not be understood as a direct measure of clinical quality. Similarly, the use of

bricolage foregrounds the structural conditions that make the active construction of care pathways necessary, but does not assume that every decision can be explained solely by institutional constraint. Individual preferences, consumer orientations, and the relational and clinical unpredictability of childbirth may also shape women's choices, and these interpretations are considered in the final discussion.

Each study also carries specific limitations, which are discussed in detail [in Chapter 6.1](#). In brief, the scoping review privileges English-language, high-income and largely Western research, so some gaps may reflect its search strategy rather than true absences; the survey is cross-sectional and partly retrospective, uses a single-item measure of satisfaction, and can identify associations but not causal relationships; and the qualitative study, based on a purposive, largely snowball-recruited sample of 26 Roma and non-Roma women, supports the exploration of varied care trajectories but is not representative and does not permit systematic comparison between all social groups or a longitudinal analysis of change.

A further conceptual boundary concerns the relationship between healthcare bricolage and theories of capital (Bourdieu, 1986). This dissertation foregrounds the how of bricolage, the practical work through which women make care pathways workable rather than systematically analysing resource mobilisation as the conversion of economic, cultural, and social capital into advantage. A capital-theoretical analysis represents an important direction for further research but lies beyond the scope of the present dissertation (see [Chapter 6.1](#)).

These limitations are discussed further in [Chapter 6](#), with particular attention to how they shape the claims that can be made across the dissertation.

1.4. Methodological overview of the dissertation

This article-based dissertation employs a multi-method research design combining a scoping review, a quantitative analysis of representative survey data, and qualitative semi-structured interviews. The studies use different forms of evidence to address complementary dimensions of inequality in childbirth care. In addition, seven expert interviews serve a contextualising rather than stand-alone analytical function.

The first study systematically maps international research on maternal experiences around childbirth and their relationship to socio-economic factors in OECD countries. It follows the PRISMA methodological guidelines (Moher *et al.*, 2009). The scoping approach is used to produce an evidence “map” that clarifies what is known, what remains under-researched, and how key concepts – such as experience, satisfaction, respectful care, and socio-economic position – have been operationalised across contexts. This broader overview

establishes the background for the Hungarian-focused studies and supports the dissertation's emphasis on inequality mechanisms.

The second study examines the socio-demographic factors of childbirth satisfaction and the perceived role of informal payments in Hungary. It relies on a representative survey conducted in Hungary between February and April 2024 among adults, including respondents with and without childbirth-related experience. The analysis combines descriptive statistics with inferential techniques to explore how satisfaction and perceptions of “better obstetric care” vary by socio-demographic characteristics. Key analytical steps include bivariate comparisons (including chi-square tests) to assess group differences, factor analysis to identify latent dimensions in perceptions of higher-quality obstetric care, and logistic regression models estimating the associations between socio-demographic predictors and dissatisfaction with childbirth among those with relevant experience.

The third study investigates how women navigate Hungarian obstetric care through their bricolage tactics post-2021. It draws on 26 qualitative semi-structured in-depth interviews conducted between 2022 and early 2026 with mothers from diverse social backgrounds, including under-researched segments at both the lower and upper ends of the social structure and across lower and higher educational groups. Interviews were conducted in Hungarian and analysed abductively using MAXQDA software.

Beyond these three studies, the dissertation also draws on seven expert interviews conducted in 2025 with professionals and civil-society actors connected to obstetric care, including midwives, doulas, a perinatal-loss support specialist, a caesarean-education specialist, a data specialist, and a journalist. These interviews are used to contextualise and triangulate the system-level processes discussed in the Hungarian context rather than as an independent empirical study; the participants' fields and roles, together with further detail on their recruitment and the interview process, are presented in [Chapter 2.3.3](#). Further methodological details are discussed in the relevant chapters.

1.5. Structure of the dissertation

The dissertation is organised into six substantive chapters. Following this introduction, [Chapter 2](#) presents the conceptual framework, empirical literature, and Hungarian institutional context. [Chapters 3–5](#) contain the three article-based studies: the scoping review, the survey-based Hungarian study, and the qualitative study of healthcare bricolage. [Chapter 6](#) synthesises their findings and discusses the dissertation's contributions, strengths and limitations, future

research directions, and practical implications. The dissertation concludes with the references and appendices.

2. BACKGROUND

2.1. Conceptual and theoretical framework

2.1.1. Reproductive governance

The concept of reproductive governance, as developed by Morgan and Roberts (2012), “serves as an analytic tool for tracing the shifting political rationalities of population and reproduction” (p. 241). It refers to the “mechanisms through which a diverse configuration of actors – such as state institutions, churches, donor agencies, and non-governmental organisations (NGOs) – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and practices” (Morgan and Roberts, 2012, p. 243). This framework is particularly useful for understanding how contemporary neoliberal reproductive discourses are framed through morality and contestations over “rights”.

The framework of reproductive governance is theoretically grounded in Michel Foucault’s concept of biopower (Foucault, 2008; Morgan and Roberts, 2012). According to the Foucauldian approach, modern states govern by managing and disciplining the physical-biological life of their population. Furthermore, biopower distinguishes between sovereign, external force and the internalisation of governance, through which subjects monitor their own intimate bodily processes (Foucault, 1991). Reproductive governance links the disciplining of individual bodies with biopolitics (the large-scale management of populations) in the landscape of neoliberalism.

Building on Foucault’s “regimes of truth” and Didier Fassin’s “politics of life,” these regimes evaluate the meaning of human existence and categorize reproductive actions as either rational or irrational (Morgan and Roberts, 2012, p. 242). This constitutes the basis of the moral dimensions of reproductive governance. These regimes are moral regimes, which refer to the privileged standards of morality used to govern intimate behaviours and public ethical judgments. Additionally, Castro and Savage argue that “these moral regimes set the stage for what has been termed ‘stratified reproduction’ [...]; that is, the different worthiness that society assigns to women and their reproductive processes” (2019, p. 124).

In the conceptualisation of reproductive governance, the authors point to the phenomenon that within a neoliberal context, there is a shift from technocratic, vertical

population control to a rights-based approach (Morgan and Roberts, 2012, p. 245). This proliferation of “rights-talk” has created a rivalry over rights, allowing the claims of different rights-bearing citizens to be pitted against one another, for example the unborn vs. women, creating a “foetal citizen” whose right to life is often positioned in opposition to women’s reproductive and sexual rights; and individual vs. collective rights, often focusing on individual “choice” and consumption against collective human rights or “natural rights” based on divine law.

To add to this, reproductive governance highlights how political-economic processes, such as the privatisation of medicine and the expansion of women’s formal labour, shape reproductive rationalities. The retraction of state commitments to public health often occurs under the banner of a consumer’s “right to choose,” effectively transforming citizens into consumers of privatised reproductive technologies (Morgan and Roberts, 2012, p. 249). Ultimately, this framework allows researchers to examine how global economic logics and national political strategies produce specific subject positions, such as the “responsible mother,” the “resource-depleting migrant,” or the “innocent unborn”.

The reproductive governance framework has been applied across a wide range of reproductive fields, including reproductive rights, family policy, abortion, and obstetric care (El Kotni and Singer, 2019; Mishtal, 2019; Kövér, 2020; Suh, 2019; Castro and Savage, 2019). In research on childbirth, its particular value lies in connecting state and institutional arrangements to moral distinctions among mothers, differentiated standards of care, and women’s position within medical institutions.

In the field of childbirth-related analysis, the study of Castro and Savage (2019) has outstanding relevance for this dissertation both theoretically and empirically, as it shows a striking resemblance to the Hungarian case. The authors utilize the framework of reproductive governance to analyse how obstetric violence, “the appropriation of women’s body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life” (República Bolivariana de Venezuela 2007, cited in Castro and Savage, 2019, p. 123), in the Dominican Republic’s public health system functions as a mechanism of social control. In the specific field of Dominican obstetric care, this governance manifests through a sharp “fault line” that separates wealthy “consumers” in the private sector from impoverished “charity beneficiaries” in public hospitals (Castro and Savage, 2019, p. 124). This division produces distinct moral regimes, where those in the public sector are often treated

as “favor beggars” whose rights to dignified care are frequently disregarded by health professionals and the state.

The paper connects this governance to the production of self-controlled subjects through the clinical environment of public maternity hospitals. The authors found that many women routinely endure poor health system conditions, such as sharing a single hospital bed with up to four other patients or experiencing a total lack of physical privacy, yet they often do not categorize these experiences as mistreatment. Instead, these women frequently justify the lack of resources as an inevitable part of the “process” due to high patient volume. This acceptance is a central component of reproductive governance, as the state and medical institutions normalize a standard of care for the poor that would be considered unacceptable for the wealthy: “...public hospitals shape women’s expectations for their birth experiences by normalizing poor health system conditions and constituting a moral regime for the poor.” (Castro and Savage, 2019, p. 128), thereby reinforcing a system of stratified reproduction.

Furthermore, the authors mobilize the concept of adaptive preference to explain how reproductive governance effectively limits women's autonomy. Adaptive preference is defined as “the preference to put up with abuse” (Castro and Savage, 2019, p. 132) when an individual recognizes that more desirable options are inaccessible due to their structural deprivation. Consequently, obstetric violence serves as a coercive tool that “constricts the roles of women in directing their own childbirth processes” (Castro and Savage, 2019, p. 132), transforming the female body into an object of state-managed medical procedures rather than an autonomous participant in the birthing experience.

Within this dissertation, reproductive governance therefore provides a framework for examining how demographic aims, welfare arrangements, medical authority, and moral expectations become embedded in the functioning of childbirth care. It makes visible the political and institutional conditions under which women encounter obstetric services, but it does not in itself fully explain how they respond to fragmented provision or attempt to make care pathways workable. Healthcare bricolage brings this situated and practical dimension into the analysis.

2.1.2. Healthcare bricolage

The concept of bricolage originates in Lévi-Strauss's anthropological work (Lévi-Strauss, 1966) and has subsequently been adapted across several fields of social research. At its core, bricolage refers to acting with heterogeneous resources that are already available or become accessible during the process, rather than selecting the optimal means for a fully predetermined

course of action. In Lévi-Strauss's original formulation, the *bricoleur* – who makes do with the tools and materials “at hand” – is contrasted with the engineer, who works with purpose-built tools according to a predetermined plan (Lévi-Strauss, 1966). Its analytical significance therefore lies not simply in improvisation or creativity, but in the way available materials, knowledge, relationships, and institutional opportunities shape both the pathway pursued and what can realistically be achieved.

From this anthropological starting point, the concept has travelled widely. The theoretical, conceptual, methodological, and field-specific application of bricolage is extensive. In qualitative methodology it has been used to characterise the researcher as *bricoleur*, assembling multiple theoretical and methodological tools to address complex problems (Rogers, 2012). More influentially for the present purpose, bricolage has become a central concept in the study of entrepreneurship, innovation, and organisation, where it describes how actors “make do by applying combinations of the resources at hand to new problems and opportunities” (Baker and Nelson, 2005, p. 333, as cited in Mateus and Sarkar, 2024). A recent systematic review maps this now-extensive literature and organizes it into a multi-level framework around the actor (who), the context (when), the process (how), and the outcomes (what) of bricolage, while also documenting subtypes (Mateus and Sarkar, 2024). What recurs across these strands is a common core: bricolage is typically enacted under conditions of resource constraint and uncertainty, and it works through the recombination of existing resources for new purposes (Mateus and Sarkar, 2024).

This variety is reflected in the range of domains and settings in which bricolage has been applied, from entrepreneurial venturing in resource-scarce environments to service value creation (Witell *et al.*, 2017), design (Louridas, 1999), and institutional change (Mateus and Sarkar, 2024). The concept has also been taken up in the Hungarian and post-socialist context: Kuczi (2011), in his study of small enterprise and its social environment, distinguishes *bricolage* (*barkácsolás*) – the recombination of ready-made elements at hand — from what he terms *kreácsolás*, the more active, innovative reworking of one’s social surroundings into a viable enterprise (Kuczi, 2011, p. 114). His account illustrates how the logic of “making do” with available social and cultural resources has been used to interpret economic action in the specifically Hungarian setting (Kuczi, 2011).

These broader traditions provide important background, but the strand of bricolage theory most relevant to this dissertation is the one that focuses on healthcare-related fields rather than entrepreneurial or organisational ones. Building on this broader tradition, Phillimore and colleagues developed the concept of healthcare bricolage to describe the “creative

mobilisation, use and re-use of wide-ranging resources, including various knowledge resources, and multiple ideas, materials and networks in order to address particular health concerns” (Phillimore *et al.*, 2019a, p. 236). Their work has primarily examined how residents of superdiverse neighbourhoods combine formal healthcare, informal knowledge, social relations, and services located across different welfare and healthcare systems (Phillimore *et al.*, 2015, 2018, 2019a, 2019b). Healthcare bricolage is therefore not synonymous with the use of several providers. Its focus is on the situated work through which heterogeneous resources are assembled into a care pathway.

This dissertation extends the concept to childbirth within a formally universal healthcare system. In this context, bricolage is not limited to superdiverse communities, migrant or otherwise marginalised populations whose needs are poorly recognised by mainstream provision. It may also become relevant to users whom the healthcare system is formally designed to serve when care pathways are experienced as fragmented, uncertain, or insufficiently responsive. Moreover, unlike healthcare bricolage undertaken in response to an existing illness or discrete health concern, childbirth-related bricolage often begins in anticipation. Women may combine public and private services, digital and professional knowledge, social networks, geographical mobility, and relational support before birth in an attempt to secure predictability, continuity, control, and respectful treatment.

The active mobilisation of resources should not, however, be treated as evidence of unconstrained individual choice. Agency and structural constraint are not mutually exclusive. Some bricolage practices may reflect consumer orientations, preferences for particular models of childbirth, or attempts to manage the relational unpredictability that no healthcare system could eliminate entirely. Nevertheless, the dissertation interprets bricolage primarily through structural constraint because, in the empirical material, its dominant function was not the pursuit of unlimited choice or enhanced comfort. It was more often an attempt to secure basic conditions of care, including information, continuity, credibility, dignity, and protection from anticipated mistreatment.

Approaching bricolage primarily as individual resilience or self-empowerment would also carry an analytical risk. In a context characterised by expanding private provision and uneven public services, the celebration of patients’ resourcefulness can obscure the transfer of responsibility for coordination and predictability from institutions to women and their families. Bricolage is therefore used here as a diagnostic lens: it makes visible both the institutional conditions that require women to make care workable and the unequal burdens involved in doing so. At the level of the dissertation as a whole, however, the concept has a broader

function. It shows how the governing arrangements identified through reproductive governance are encountered, negotiated, and sometimes partially circumvented in everyday care trajectories. At the same time, the capacity to mobilise resources and the effectiveness of these resources are socially differentiated, which makes an intersectional analysis necessary.

2.1.3. Intersectionality as an analytical approach

Intersectionality is used in this dissertation as an analytical approach for examining how reproductive governance and women's capacity to navigate obstetric care are differentiated across social positions. Historically, the term and theoretical concept of intersectionality emerged from Black feminist theory in the 1980s. Crenshaw, in her famous intervention (1989), argues against a single-axis framework for approaching discrimination and for adequately acknowledging the experiences of Black women; experiences that can differ in important ways from those of Black men and white women. She illustrates this narrowness through three legal cases in which Black women went to court, showing how institutional categories of discrimination can render compounded harms unintelligible.

This argument is not only relevant to the broader literature, but it also offers a useful point of connection to analyses of racial oppression of Roma (Kóczé, 2020), and discriminatory cases involving Roma women in the field of reproduction (Watson and Downe, 2017; Balogh and Gellér, 2019; Albert and Szilvasi, 2017). In this sense, legal disputes can be read as “visibility moments” that make structural inequalities legible, while also revealing the limits of institutional recognition when harms do not fit neatly into a single category.

The original approach to intersectionality is one in which systems of race, social class, gender, sexuality, ethnicity, and age together construct the social organisation that shapes the experiences of Black women, and that Black women, in turn, navigate and contest (Crenshaw, 1989; Hill Collins, 1990). Intersectionality, in this view, is not primarily an additive model of “multiple identities,” but an analytical approach to intersecting power relations and the institutional arrangements that reproduce them.

Building on this tradition, complex intersectionality provides a historical, relational, and systemic perspective that avoids reducing structural inequalities to individual identities or the accumulation of separate disadvantages (Csányi and Kováts, 2020). It directs attention to the social and institutional relations through which categories such as gender, class, ethnicity, and age acquire meaning and produce unequal consequences.

In this dissertation, intersectionality is therefore not used to construct an exhaustive inventory of women's identities. Its main empirical focus is on how socio-economic position,

education, place of residence, and the racialisation of Roma women shape exposure to obstetric institutions, access to resources, and the possibility of being recognised as a credible and competent patient. Roma ethnicity is not treated simply as an individual characteristic. Rather, the analysis examines racialisation as an institutional and relational process that influences how women's knowledge, pain, needs, and moral worth are interpreted in healthcare encounters.

This approach connects to healthcare bricolage in two ways. First, social position shapes which economic, informational, relational resources women can mobilise. Second, it influences how effectively those resources can be converted into continuity, safety, recognition, or respectful treatment. The same amount of money, knowledge, or preparation may therefore have different consequences depending on how a woman is positioned and perceived within the institution. Intersectionality makes it possible to analyse not only unequal access to bricolage, but also unequal returns from apparently similar strategies.

2.1.4. Integrating the analytical framework

The three analytical approaches used in this dissertation address different but interconnected dimensions of childbirth care. Reproductive governance provides the broadest framework: it examines how demographic objectives, state policies, welfare arrangements, medical authority, and moral expectations organise reproduction and define legitimate forms of maternal behaviour. Intersectionality shows that these governing arrangements do not position or affect all women in the same way. Healthcare bricolage, in turn, captures the situated practices through which women respond to these conditions and attempt to construct workable care trajectories.

Their relationship can be understood as a movement from governing arrangements, through differentiated institutional positions, to everyday navigation. Reproductive governance shapes the formal rules, market opportunities, professional hierarchies, and moral classifications within which childbirth takes place. These conditions create different forms of exposure to uncertainty and mistreatment, but also different possibilities for responding to them. Women mobilise money, knowledge, social relations, and private or public services, yet both the availability and effectiveness of these resources depend on their social positions. Bricolage therefore makes reproductive governance observable at the level of everyday institutional encounters, while intersectionality explains why the need for bricolage, its available forms, its costs, and its potential outcomes are unequally distributed.

The three concepts are integrated to differing degrees across the three studies, most fully in [Chapter 5](#), which primarily interprets bricolage as navigation around reproductive

governance, while also raising the question of whether women's individual bricolage is itself embedded within broader structures of governance. The material poses this question but cannot fully settle it: women's practices appear primarily as navigation around governance, yet the same practices may also be read as a mode of responsabilisation, whereby the work of coordinating fragmented care is effectively placed on women and their families as part of reproductive governance.

However, this framework does not assume that every form of bricolage is wholly imposed or that individual preferences and consumer orientations are irrelevant. Structural compulsion, personal agency, and consumer demand may coexist. The central analytical question is therefore not whether women exercise agency, but under what institutional conditions, with which resources, and at what cost they are required to exercise it. When women must individually coordinate fragmented services and secure basic conditions of care, bricolage can provide partial protection while simultaneously individualising institutional responsibility and reproducing inequalities in room for manoeuvre.

2.2. Childbirth experiences, satisfaction and inequalities: empirical literature

This section clarifies the main empirical and conceptual distinctions required for interpreting the studies that follow without reproducing the article-specific literature reviews. It first distinguishes childbirth experience, childbirth satisfaction, and satisfaction with obstetric care; it then summarises international evidence on social inequalities in childbirth experiences and care; and finally situates these debates within the Hungarian literature.

2.2.1. Conceptualising childbirth experience and satisfaction

Childbirth has increasingly been approached as a multidimensional social process rather than a purely clinical event. Although clinical outcomes remain central, research increasingly recognises that women's experiences of care matter in their own right. International guidance therefore emphasises the importance of a positive childbirth experience and respectful intrapartum care (World Health Organisation, 2018).

Negative or traumatic birth experiences have been associated with postpartum mental health problems, including postpartum depression, anxiety, and PTSD symptoms, and they can also affect bonding, breastfeeding, and decisions about future pregnancies (De Schepper *et al.*, 2016; Grisbrook *et al.*, 2022; Gottvall and Waldenström, 2002; Read *et al.*, 2012; Sawyer *et al.*, 2013).

The concepts of childbirth experience, childbirth satisfaction, and satisfaction with maternity or obstetric care overlap, but they are not interchangeable. Childbirth experience is the broadest of these terms, encompassing the bodily and emotional experience of labour, the clinical course and outcome of birth, and encounters with professionals and institutions. Satisfaction with obstetric care refers more specifically to a person's evaluation of the services and treatment received. Measures of childbirth satisfaction may combine elements of both, which partly explains the inconsistency of terminology across studies (Sawyer *et al.*, 2013; Nilvér *et al.*, 2017).

As in health-services research more generally, satisfaction can be understood as a subjective evaluation shaped by preferences, expectations, perceptions of what occurred, and the comparisons through which an experience is interpreted (Sitzia and Wood, 1997; Sawyer *et al.*, 2013). Some approaches emphasise whether care fulfilled a person's needs, whereas discrepancy approaches focus on the relationship between prior expectations and actual experiences. Childbirth adds further complexity because the evaluation may simultaneously incorporate a major bodily event, the health of the mother and infant, pain and interventions, perceived control, and the quality of interpersonal care.

Satisfaction should therefore not be treated as a direct measure of objective clinical quality. A clinically safe outcome does not in itself establish that care was respectful, adequately communicated, or experienced positively; conversely, a positive retrospective evaluation does not demonstrate that all professional standards were met. Satisfaction instead captures a patient-reported dimension of quality that complements rather than replaces clinical and organisational indicators. Its interpretation may also be affected by expectations, prevailing norms concerning what women should accept during childbirth, the outcome of the birth, and the interval between the event and measurement (van Teijlingen *et al.*, 2003; Sawyer *et al.*, 2013).

Research suggests that women's evaluations of childbirth are shaped particularly strongly by relational and subjective dimensions of care, including expectations, perceived support, communication and participation in decisions. These dimensions may be more influential than individual clinical characteristics of labour considered separately (Hodnett, 2002). Mode of delivery, emergency procedures, pain relief, and birth preparation can still matter, but their effects are intertwined with communication, consent, perceived control, and relational support. The same clinical intervention may therefore be evaluated differently depending on whether it was explained, consented to, and accompanied by respectful treatment.

The measurement of satisfaction reflects these conceptual differences. Multidimensional instruments distinguish among specific components of childbirth and care. The ten-item Birth Satisfaction Scale-Revised, for example, measures quality of care provision, women's personal attributes, and stress experienced during childbirth (Hollins Martin and Martin, 2014). Other studies use a single global item. Such an item allows respondents to provide an overall evaluation without researchers determining in advance how the different dimensions should be weighted, but it cannot identify which components produced that evaluation and does not capture the full multidimensionality of childbirth experience (Sawyer *et al.*, 2013).

[Chapter 4](#) adopted the latter approach. Satisfaction was measured retrospectively through the single question: “How satisfied were you with the obstetric care during the birth of your (youngest) child?”, with four response categories ranging from very satisfied to completely dissatisfied. The gender-neutral wording allowed both mothers and fathers with relevant childbirth-related experience to answer. The measure is therefore interpreted here as a global, retrospective evaluation of satisfaction with obstetric care during childbirth, rather than as a multidimensional measure of the complete childbirth experience or an assessment of objective service quality. The subsequent dichotomisation of the four response categories for the regression analysis further limited the possibility of examining variation within the satisfied and dissatisfied groups. The broader adult sample was used separately to analyse general perceptions of access to better obstetric care; the satisfaction analysis was restricted to respondents with relevant experience.

Research on childbirth in Hungary is relatively extensive and has increasingly addressed the quality of care, childbirth satisfaction, medical interventions, institutional responsiveness, and unequal access. One strand of this literature draws attention to the normalisation of pain, suffering, and women's submission to medical authority, including the expectation that birthing women should comply with professional instructions rather than act as participants in decision-making (Csányi and Kerényi, 2021). Related work identifies communication, difficulties in assessing information, lack of trust, vulnerability, and institutional variation as recurring features of Hungarian obstetric care (Kisdi, 2016).

Hungarian satisfaction research broadly supports the multidimensional interpretation outlined above. Engler *et al.* (2021), analysing a large-scale survey of Hungarian mothers, found that positive evaluations were associated with social support, the presence of a partner or relative, the possibility of choosing an obstetrician or midwife, and women's financial position. Caesarean birth was associated with lower satisfaction, but qualitative research

indicates that mode of delivery and the number of interventions do not determine women's evaluations independently of relational and contextual factors. In Kisdi's (2016) interviews, the attitude of the midwife, social support, the duration of labour, and the extent to which expectations were met were among the most important influences on retrospective evaluations.

The representative Cohort '18 study found that approximately one in ten mothers evaluated childbirth negatively (Veroszta *et al.*, 2022). More recent Hungarian research has further emphasised autonomy, access to information, meaningful participation, and being treated as a competent actor (Kisdi and Földházi, 2024). Using the multidimensional BSS-R, Nagy and Lafarge (2023) also found associations between satisfaction and parity, place and mode of birth, pain relief, and adherence to a birth plan, while indicating that interpersonal and institutional factors not fully captured by the scale may also be important. Taken together, these studies suggest that medical events and relational experiences cannot be analysed as separate determinants of satisfaction.

Because these Hungarian findings draw on different measurement traditions, they are not always directly comparable. Studies such as Nagy and Lafarge (2023) employ the multidimensional BSS-R, whereas Engler *et al.* (2021), the Cohort '18 study (Veroszta *et al.*, 2022), and the survey analysed in [Chapter 4](#) rely on single or more global evaluations. As noted above in relation to measurement, single-item and multidimensional instruments capture satisfaction at different levels of specificity, which partly accounts for the divergent and occasionally contradictory associations reported across the Hungarian literature and reinforces the need to interpret satisfaction findings in light of how they were measured.

2.2.2. Social inequalities in childbirth experiences and care

Both internationally (Daoud *et al.*, 2015; Tian *et al.*, 2018; Vedeler *et al.*, 2023) and in Hungary, socio-demographic factors such as socio-economic position, ethnicity, and education are repeatedly identified as relevant to childbirth-related outcomes and care experiences (Nagy and Lafarge, 2023; Engler *et al.*, 2021; Szabó and Veroszta, 2022, 2024). Inequalities in childbirth tend to emerge through combined mechanisms: uneven access to quality care and higher-standard services, differential exposure to mistreatment and discrimination, and unequal ability to obtain information, ask questions, and evaluate available options.

These inequalities concern not only differences in clinical outcomes but also recognition, credibility, communication, and room for manoeuvre within institutions. This is where the empirical literature connects to the intersectional approach outlined in [Section 2.1.3.](#):

social positions shape both women's exposure to obstetric institutions and the resources available for navigating them.

The scoping review presented in [Chapter 3](#) mapped 18 OECD-country studies published between 2013 and 2024 on socio-economic factors and maternal experiences around childbirth (Udvari, 2023). Women in lower socio-economic positions frequently appeared more exposed to negative experiences, although the direction and strength of associations were not consistent across every dimension. Education illustrates this ambiguity: some studies associate higher education with more positive evaluations, whereas others find greater dissatisfaction among highly educated women, potentially because more specific expectations remain unmet.

The review is more conclusive in mapping recurring associations than in identifying the institutional mechanisms that produce them. Most of the included studies were quantitative, while women's narratives and qualitative analyses of how inequalities were experienced were underrepresented. The review therefore established the international patterning of childbirth experiences, but left greater scope for examining how unequal care is anticipated, interpreted, and navigated. [Chapters 4](#) and [5](#) address different parts of this gap.

Hungarian research also demonstrates that access to these conditions is socially stratified. Socio-economic position and education shape the use of public and private services, access to information, and opportunities to secure higher-standard or more individualised care (Baji *et al.*, 2017; Szabó and Veroszta, 2021, 2022). Roma women are more likely to rely exclusively on publicly funded care and to encounter disadvantaged conditions, insufficient information, and discriminatory or racialised treatment (Balogh-Szabó, 2023; Szabó and Veroszta, 2024; Balogh, 2025). Although the independent effect of ethnicity cannot always be separated statistically from accumulated socio-economic disadvantage, the qualitative and legal literature documents forms of racialised classification and mistreatment that cannot be reduced to income or education alone. Satisfaction must therefore be interpreted alongside unequal access, institutional treatment, and women's differential capacity to negotiate care.

Overall, the empirical literature shows that childbirth satisfaction is neither a simple reflection of clinical outcomes nor an entirely individual attitude. It is shaped by the interaction of the course of birth, expectations, interpersonal treatment, institutional responsiveness, and socially differentiated access to resources.

These patterns are embedded in Hungary's hybrid healthcare system, in which state-funded provision coexists with an expanding private sector and the continuing legacy of informal payments. The institutional development of this system and the 2021 reform are

discussed separately in [Section 2.3.](#) rather than repeated here (Baji *et al.*, 2017; Gaal *et al.*, 2021; Szabó and Veroszta, 2021).

Before turning to the empirical studies, the next section situates these patterns within the Hungarian policy and institutional context, moving from family policy as a form of reproductive governance to the organisation and recent transformation of obstetric care.

2.3. Hungarian context

2.3.1. Family policy as reproductive governance³

This subsection situates Hungarian family policy within broader demographic and political rationalities that make reproduction a privileged object of state intervention. Family policy as such does not constitute a central focus of analysis in this dissertation, but it provides an important contextual framework for understanding childbirth and obstetric care in Hungary. In contemporary Hungary, family policy occupies a prominent position within the social policy framework (Szikra, 2018b; Szikra and Autischer, 2025), and its primary goal is to encourage childbearing, most often framed as a response to a “demographic crisis” (Szalma and Herke, 2025). Since the 2010s, the government has strengthened pronatalist policies that seek to increase births through financial and social support to families with children; this agenda is also reinforced through public rhetoric, for example, as former president Katalin Novák stated in a lecture at Brigham Young University, “having children saves the world” from the “demographic ice age” in Europe.⁴ These policies, in practice, promote a traditional family model and operate as a normative project that defines which family forms are publicly valued.

Accordingly, pronatalism can be understood both as a policy orientation and as a broader societal attitude (Murinkó and Szalma, 2022). It is typically grounded in the assumption that having children is a fundamental human experience and a means of ensuring national continuity, while also being framed in economic terms such as sustaining the workforce and mitigating the consequences of ageing societies (Bauer, 2022). Hungarian

³ Parts of the section “Family Policy as Reproductive Governance” draw on a blog post previously published by the author: Udvari, O. (2024) ‘Family-Friendly Hungary: A Look at Family Policies, Demographic Changes, and Selective Pronatalism’, *Transforming Anxieties of Ageing*, 16 October. Available at: <https://transforming-anxieties.ios-regensburg.de/family-friendly-hungary/>.

⁴ MTI (2023) ‘Novák Katalin: A gyermekvállalás menti meg a világot’, *Origo*, 27 September. Available at: <https://www.origo.hu/itthon/2023/09/novak-katalin-a-gyermekvallalas-menti-meg-a-vilagot>.
Népszava (2023) ‘Novák Katalin a nyugati demográfiai jégkorszakot taglalva ösztönözte gyermekvállalásra az amerikai fiatalokat’, *Népszava*, 27 September. Available at: https://nepszava.hu/3210180_novak-katalin-egyedul-allamok-utah-demografia-gyermekvallalas.

research on contemporary family policies frequently highlights the selectivity of this pronatalist approach, examining policy goals, target groups, and effectiveness (Szikra, 2014).

In practice, pronatalism rarely operates as a universal encouragement of “all births.” Instead, policy designs often privilege particular family forms and social groups, turning pronatalism into a selective, stratified project. Pronatalist policies typically work through incentives such as tax breaks, housing support, and extended parental (often maternal) leave, and they can also frame childbearing as a patriotic duty (Tóth, 2012). Yet access to these resources is uneven, and non-traditional families may be implicitly positioned as less “worthy” within the pronatalist agenda. This “worthiness” logic is consequential because it shapes not only who is supported, but also whose reproduction is publicly celebrated and whose needs are rendered secondary.⁵

These dynamics are often captured by the concept of selective pronatalism, which refers to the promotion and encouragement of reproduction among certain groups while discouraging or excluding others (Hašková and Dudová, 2020). In most contexts, the implicitly desired group is middle-class, employed, white, heterosexual, married couples, while same-sex couples, singles, unmarried couples, people from lower classes, the unemployed, ethnic minorities, and immigrants may face significant barriers to accessing support and recognition (Szikra, 2018b; Kramarics, 2025; Fodor, 2022). Such stratification also reinforces traditional gender roles, and pronatalist agendas often target women particularly strongly by positioning them as responsible for biological and social reproduction (Bauer, 2022, p. 59; Fodor, 2022).

Importantly, selective pronatalism may also intersect with the governance of reproductive autonomy more broadly, including debates around access to contraception and abortion, and – at the extreme end – cases of coercive reproductive restriction, such as the 2001 case in which a Roma woman was sterilized without consent in a Hungarian hospital (ERRC, 2006).

From the perspective of reproductive governance, Hungarian family policy can thus be read as a key institutional arena where demographic rationalities are translated into concrete mechanisms: economic inducements, moral injunctions, and normative definitions of “worthy” family life. This matters for the dissertation’s focus on childbirth because policy-level demographic goals do not remain abstract; they shape the moral and institutional environment in which pregnancy and birth are organised, experienced, and evaluated. In the next subsection,

⁵ For example, political reactions to the birth of a Roma child illustrate how reproduction can be evaluated differently through ethnicised ideas of national belonging: Medvegy, G. (2015) ‘Rikárdó lett a DK-sokból’, *24.hu*, 3 January. Available at: <https://24.hu/belfold/2015/01/03/rikardo-lett-a-dk-sokbol/> (Accessed: 11 March 2026).

I therefore turn to obstetric care as the healthcare field where these governance logics become materially visible through access, institutional practices, and everyday interactions.

2.3.2. Obstetric care within healthcare

Hungary's healthcare system is formally built on a state-funded model: publicly financed services are available to those insured through social security contributions, most commonly linked to employment status. Within this framework, antenatal and obstetric care are institutionally well-established and, on paper, comprehensive, involving multiple professional roles (e.g., obstetricians, midwives, general practitioners, and health visitors) and structured care pathways. At the same time, over the past decade the private sector has expanded rapidly, producing an increasingly hybrid landscape in which many patients combine public and private providers to secure timely care, continuity, and a greater sense of predictability.

This hybridisation has also intensified inequalities. As public provision has faced resource constraints and uneven institutional responsiveness, faster access and more “controllable” care pathways have increasingly depended on financial resources. These dynamics are especially visible in obstetrics, where private antenatal care can function as a compensatory strategy alongside public hospital birth, and where “choice” is often structured by social position rather than being equally available. In this context, access to higher-quality, or at least more predictable care becomes intertwined with the ability to mobilize money, information, and social networks.

A further historically embedded feature of Hungarian (and broader Central and Eastern European) healthcare is the practice of informal payments (Udvari and Szalma, 2025). Informal payments functioned as a form of out-of-pocket expenditure through which patients attempted to secure better treatment and more personalized relations within the public system. In obstetric care, this was closely tied to the institution of the “chosen obstetrician,” where women sought continuity across antenatal care and birth, and where predictability and trust were often built through informal financial arrangements.

A major institutional turning point came with the 2021 reform, which criminalized informal payments and restructured health workers' employment conditions, including restrictions on dual practice and significant salary increases for physicians. The Act replaced the previous public employment relationship, bringing health workers under central control. At the same time, doctors received an unprecedented 120% salary increase to be phased in over three years. The law imposed several restrictions, including prohibiting side jobs without prior approval, banning parallel private practice for the same patient, and allowing the involuntary

transfer of workers to other facilities for up to two years (Gaal *et al.*, 2021). These measures transformed the healthcare system, particularly obstetric care. In obstetric care, these changes reshaped established expectations: the previously common continuity mechanism of a chosen doctor largely disappeared, and care became more dependent on contingency (who is on duty at the time of birth). At the same time, the reform did not automatically resolve deeper structural issues.

These system-level dynamics – hybrid provision, stratified access, the legacy of informal payments, and the institutional consequences of the 2021 reform – form the immediate background for the dissertation’s empirical questions. [Chapter 4](#) and [Chapter 5](#) address these issues in greater detail: the survey-based study examines how satisfaction and the perceived role of informal payments relate to socio-demographic position, while the qualitative study focuses on how women navigate the post-2021 landscape through combining resources, services, and relationships in order to secure predictability, continuity, and dignity.

2.3.3. Contextual sources and expert interviews

To complement the published literature and contextualise the system-level processes described above, this part of the dissertation also draws on seven interviews with experts connected to obstetric care through their professional and, in some cases, civic work. The interviews provide additional insight into the institutional conditions that shape mothers’ position and their access to and experiences of childbirth care.

It is necessary to mention the civil sector when dealing with Hungarian obstetric care and its main characteristics, because it plays a particularly visible role in this field.⁶ In 2022, I participated in a six-month period of field observation in a Budapest-based women’s and mothers’ organisation as a form of preliminary familiarisation with the field. This experience together with contacts developed within that network and through approaching other institutions served as the practical starting point for recruiting interviewees for the expert interviews.

Although it was not an intentional sampling criterion, all interviewees were women. Many of them became engaged in the topic through their own childbirth experiences and subsequently professionalized their involvement. Actors outside core public institutions were also easier to reach and more open to participation than central institutional stakeholders. The

⁶ The most prominent NGOs and advocacy movements in this field include the EMMA Association, Másállapotot a Szülészetben!, and Ablak a világra, among others.

participating experts therefore occupy a distinctive position between formal childbirth care and its activist and non-institutionalised, including NGO, fields.

Interviews with expert informants from the field were conducted in 2025. Six interviews took place online and one in person. They were audio-recorded and lasted between 45 and 60 minutes. [Table 1](#) shows the participants' fields, main activities, and connections to the obstetric field.

Table 1. List of experts interviewed for the study

Participants numbers	Field – occupation	Main activities, role
<i>Interviewee 1</i>	midwife	antenatal care, out-of-institution births
<i>Interviewee 2</i>	data specialist (civil sector)	collecting survey data
<i>Interviewee 3</i>	perinatal loss support (civil sector)	working in a multidisciplinary expert team, providing support to families, also to healthcare professionals
<i>Interviewee 4</i>	caesarean education specialist (civil sector)	social enterprise, trainings, knowledge transfer
<i>Interviewee 5</i>	doula	antenatal and birth support
<i>Interviewee 6</i>	journalist	writing articles on social issues, with a particular focus on childbirth and childbearing
<i>Interviewee 7</i>	doula	antenatal and birth support

The interviews are used here for contextualisation and triangulation rather than as a stand-alone study. These interviewees are treated as crucial informants for institutional background information because several themes recurred across accounts and converged with patterns documented in literature. At the same time, their accounts should not be treated as representative of the full professional field: the material reflects a small and predominantly civil-society-oriented group, while core institutional actors, including practising obstetricians, are not represented.

The interviews covered several topics, focusing primarily on the interviewees' professional paths and motivations, their general overview of obstetric care, and what kinds of challenges and positive examples they see in the field (Appendix, [section 8.2.](#)).

2.3.4. Main characteristics and challenges of Hungarian obstetric care

The following section synthesises the expert accounts with existing research to outline the key structural constraints that shape women's access to and experiences of Hungarian obstetric care. Five interrelated dimensions structure the discussion that follows. I first address (1) the difficulty of accessing systematic data on childbirth care, then turn to (2) the fragmentation of the care system itself, and (3) its hierarchical and slowly renewing character. I then discuss (4) the persistent inequalities that shape access to higher-quality services, before finally shifting focus to (5) how mothers are positioned within this system. Although presented separately for clarity, these dimensions are deeply interconnected: data opacity reinforces fragmentation, hierarchy sustains inequality, and together they define the terrain mothers must navigate.

2.3.4.1. Data limitations and institutional opacity

First, it remains highly challenging to *access systematic data* on many aspects of childbirth care and care quality in Hungary. Data access is a major constraint because there is a lack of official, systematic, and harmonized data collection and public availability regarding childbirth-related indicators. Two interviewees – one working as a journalist and one with a stronger data-focused profile – also emphasized this gap, noting that even when questions about quality and safety are widely discussed, they are often difficult to answer with reliable, comparable data.

There are, however, several alternative and experience-based data sources that attempt to fill this void. These include platforms that collect women's birth stories (Másállapotot a Szülészetben)⁷, initiatives that map problematic practices and corruption-related concerns in maternity care through anonymous narratives submitted by mothers (Így szültem)⁸, as well as databases based on online convenience surveys completed by mothers (Ablak a világra)⁹ and projects collecting video narratives of birth experiences (Hoztam-e világra)¹⁰. Most of these efforts are run by NGOs or other independent actors. While they provide valuable insight into lived experiences and recurring patterns, they are not harmonized with one another and cannot offer a systematic or representative overview of the issues they document. In this sense, fragmented data availability both reflects institutional opacity and strengthens the case for

⁷ Available at: <https://masallapotot.hu/a-ti-torteneteitek/>.

⁸ Available at: <https://igyszultem.hu/#/>.

⁹ Available at: <https://www.ablakavilagra.com/>.

¹⁰ Available at: <https://www.hoztamevilagra.hu/>.

experience-based research capable of making patterns visible that remain absent from (non-)official statistics.

Naturally, some official data do exist, for example, from the Central Statistical Office or National Health Insurance Fund of Hungary (Nemzeti Egészségbiztosítási Alapkezelő; NEAK) yet these typically cover only selected dimensions and are not consistently available for all relevant aspects of care quality, experience, and access. Moreover, additional datasets are likely collected locally (e.g., at the hospital level), but their availability is uncertain. As one interviewee noted, institutions may have limited incentives to make such data accessible, particularly when disclosure could expose quality gaps or accountability issues (Interviewee 6).

2.3.4.2. Fragmentation of the care system

Beyond data fragmentation, *fragmentation of the system* itself is a defining feature of Hungarian obstetric care. This is often described as a broader characteristic of the Hungarian healthcare system, but interviewees and the literature suggest that it is especially pronounced in maternity care. A key issue is the absence of a unified and consistently implemented national protocol in everyday obstetric practice. Although professional guidelines and periodically updated recommendations do exist (e.g., Belügyminisztérium, 2025), often aligned with international standards and evidence-based approaches, these tend to remain at the level of recommendations rather than being applied systematically across institutions.¹¹ Several experts confirmed this in practice: two interviewees mentioned having participated in consultation or feedback processes around guidelines, yet, as one put it, the input may or may not be taken into account. As a result, guidelines frequently function as optional templates that may be followed in one setting and ignored in another, while monitoring, follow-up, and enforcement remain unclear or inconsistent.

Several interviewees evaluated the “family-friendly maternity wards” program in a similar way. The governmental program aimed at developing “family-friendly” obstetric services was launched in 2018 under Government Resolution 1098/2018 (III.19.) (Government of Hungary, 2018), with the stated goal of modernizing obstetric, neonatal, and PIC (perinatal intensive care) units and making the environment more supportive for families and the birth experience more positive. In practice, however, experts suggested that infrastructural

¹¹ Kőrösi, K. (2025) ‘Megújult a szülészeti irányelv: előrelépés vagy elvesztegetett lehetőség? És mit jelent a szülő nők számára praktikusán?’, *WMN*, 3 March. Available at: <https://wmn.hu/ugy/64351-megujult-szuleszeti-iranyelv-2025> (Accessed: 11 March 2026).

improvements alone do not necessarily translate into harmonized care practices, clearer accountability, or consistently improved experiences, especially when the implementation of standards remains uneven across hospitals.

The institutional boundaries reshaped by the 2021 reform are also visible in the connections between public and private provision. Interviewees pointed to practical boundary conditions that can push women back into public provision in certain situations, for example, earlier-than-term births (before 37 weeks) or complications involving the baby, as Interviewee 3 mentioned. These examples highlight that “choice” is often conditional and that care pathways remain dependent on institutional capacity and risk categorisation.

2.3.4.3. Hierarchy and slow institutional renewal

A third recurring challenge is the *hierarchical and slowly renewing character of the system*. This is often discussed as a feature of Hungarian institutional life more broadly, but it takes a particularly sharp form in obstetric care. Hierarchy operates on multiple levels: between doctors and patients, and within institutions between different professional groups. Within this hierarchical environment, fear also becomes a structuring element; on the provider side, interviewees described both position-related anxieties and the weight of responsibility and liability. Several experts spoke about generational differences, noting that younger professionals may bring more innovative or patient-centred perspectives, yet they often encounter rigid institutional “walls” rooted in authority and established routines. Some interviewees linked this to early burnout or, alternatively, to resignation and adaptation rather than sustained renewal.

Obstetrics was repeatedly described as a male-dominated field, although interviewees also observed a changing trend as more women enter the profession. While this feminisation can be read as a positive development – potentially more responsive to the needs articulated by birthing women – interviewees were cautious about assuming that female professionals automatically produce better birth experiences. One interviewee noted that, in a highly vulnerable state, dismissive comments from a female professional may sometimes feel harder to “brush off” than stereotypically rude behaviour from a male doctor, even though the same interviewee also emphasized that negative treatment by male professionals can be particularly risky in cases where women carry prior experiences of abuse or trauma.

Across interviews, there was a strong call for more consistently evidence-based approaches, often anchored in international research and comparative practices. One interviewee summarized the current Hungarian pattern through the well-known frame of “too

little, too late” versus “too much, too soon” (Miller *et al.*, 2016), suggesting that both under-provision and over-intervention can coexist within the same system, depending on institutional context, staffing, and local routines.

Communication emerged as a central theme. Several interviewees emphasized that communication should receive far greater weight already within medical education and professional training. At the same time, one interviewee offered a more critical observation: sometimes “good communication” is reduced to polite words layered onto the same care practices that women would receive anyway. In that view, gestures that should be basic, such as greeting a patient respectfully or shaking hands, can be misrecognized as exceptional treatment rather than understood as a minimum standard. This connects to a rhetorical question raised by multiple interviewees: during childbirth, “who is visiting whom?” The implicit point is that public understanding needs to shift away from a model where women are positioned as grateful guests in the hospital, and toward a model where respectful, informative, and consent-based care is treated as the baseline, not as a discretionary favour granted by a paternalistic professional hierarchy.

2.3.4.4. Persistent inequalities in access

Multiple factors shape access to obstetric care and to higher-quality services, and a substantial body of research documents persistent *inequalities* in access (examined further in Chapter 3-5). Key background dimensions repeatedly discussed in this literature include gendered expectations and roles, ethnicity and processes of racialisation, territorial position, and socio-economic status. These dimensions also intersect in practice, producing unequal “room for manoeuvre” across mothers in terms of continuity, information, respectful treatment, and the ability to choose among care pathways. The 2021 regulatory change also affected how these inequalities play out, a point the dissertation returns to in more detail in the second and third articles.

Several interviewees emphasized that money remains a central organizing principle of access, even after recent reforms. Importantly, the role of money is not limited to private services: it shapes public provision as well (through informal mechanisms and uneven institutional resources) and it also affects out-of-institution births, where costs and regulatory conditions can create additional barriers. In this sense, financial capacity structures not only “where” women can give birth, but also what kinds of predictability, continuity, and perceived safety they can secure within and across settings.

2.3.4.5. Mothers' position: trust, information, and navigation

The fifth dimension concerns *how mothers are positioned* within the system, particularly in relation to trust, orientation, and information-seeking. This shift is especially important because the dissertation centres mothers' experiences and perspectives.

Mothers' difficulty in navigating the system is partly a direct consequence of institutional fragmentation: "it works differently everywhere," and rules and routines vary across hospitals, professionals, and local contexts. This is compounded by uneven communication, where the problem is not only the tone or interpersonal treatment, but also the inadequacy of information provision and the lack of meaningful informed consent. In response, the internet can appear to be a stable source of guidance, yet interviewees emphasized that informal "Facebook group diagnostics" – the kind of lay interpretation of test results and symptoms circulating in online communities – can be dangerous (Interviewee 3 & 4). As one expert put it, this is not how information seeking should have to work; yet women often end up feeling left alone with uncertainty.

The idea of "false safety" emerged in expert accounts partly in relation to the private sector. Interviewees pointed to the ambivalent side of private care: while it may offer improved communication, more time, or greater predictability, it may also reproduce a medicalized model of "safety," for example through unusually high rates of caesarean sections in some private settings. In this reading, "safety" can become conflated with intervention, and reassurance can be purchased without necessarily improving autonomy, informed decision-making, or long-term trust.

These navigation pressures also help explain why mothers often rely on a patchwork of supports and mediators. As one doula framed it, "they have to be like a Swiss army knife," providing practical guidance, emotional support, and interpretive help across multiple stages of the perinatal period. This points to the broader reality that the system often requires additional "invisible work" from women and their support networks; work that is unevenly available across social groups.

Taken together, these characteristics shape experiences of childbirth and attitudes toward obstetric care in ways that differ by socio-demographic and socio-economic position, an issue the dissertation examines empirically across the three articles. At the same time, interviewees also insisted that the picture needs to remain nuanced: alongside structural problems, there are positive changes and examples of good practice that matter to document. Several experts mentioned concrete institutional improvements and repeatedly referred to

specific “good” hospitals or units (including one in Pest County), while also cautioning that “one swallow does not make a summer.” In other words, these developments often remain island-like: they may persist and spread, or they may disappear without broader institutionalisation.

Interviewees also highlighted what they see as a promising shift in professional approach: strengthening attention to childbirth as a physiological process, taking women’s fear seriously in a constructive way, and supporting women’s confidence rather than replacing it with institutional control. One example raised was the idea that when a woman expresses a strong preference for caesarean section, a supportive response would be to pause and explore the reasons (“you have nine months; let us look at what this fear is about”) rather than treating the request as a purely technical choice. This orientation is closely connected to a broader normative claim voiced by several experts: what should happen is not “delivering” women, but supporting women as birth happens; an emphasis on childbirth rather than “being delivered.” Across accounts, communication and information, basic humanity, and empathy were repeatedly described as essential, both as ethical standards and as practical conditions for trust and meaningful participation.

Finally, it is important to place these observations in comparative perspective. Some of the system features described above, such as fragmented provision, uneven standards, and reliance on informal strategies, have parallels with patterns more often discussed in the literature on under-resourced healthcare systems. However, in the Hungarian case, these features coexist with European welfare-state institutions and with a growing private sector, producing a distinctive configuration in which “choice” is stratified and system navigation becomes a key determinant of perceived safety and dignity.

With the theoretical, empirical, and Hungarian institutional context established, the dissertation now turns to the three article-based studies. [Chapter 3](#) maps international evidence on the relationship between social position and maternal experiences around childbirth; [Chapter 4](#) examines population-level patterns of satisfaction and perceived access to better obstetric care in Hungary; and [Chapter 5](#) investigates how women navigate the institutional terrain described above through different forms of healthcare bricolage.

3. A SCOPING REVIEW ON THE RELATIONSHIP BETWEEN MATERNAL EXPERIENCES AROUND CHILDBIRTH AND SOCIO-ECONOMIC FACTORS IN OECD COUNTRIES¹²

Abstract

The presence of social inequalities in health care is a well-known phenomenon and a widely researched topic. Within this, issues of inequality in obstetric and midwifery care are a less explored area. Childbirth experiences are influenced by many factors, including age, socio-economic status, ethnicity, mode of delivery, and obstetric care. Women from low socio-economic backgrounds may be particularly vulnerable to negative birth experiences, with demonstrable short- and long-term effects on both the mother and her social environment. This paper uses the method of scoping review to map the international literature on the relationship between maternal socio-economic status and birth experience over the last decade in OECD countries. Based on a review of 18 articles, the paper concludes that taking socio-economic background into account is crucial for understanding the mechanisms and impact of mothers' experiences around childbirth.

Keywords: childbirth, maternal experiences, socio-economic factors, healthcare, scoping review

3.1. Introduction

The presence of social inequalities in healthcare and obstetric care is a well-known and widely researched topic. Childbirth is an intense and defining life event in which social and emotional influences can be identified, affecting not only the mother but also her immediate environment, primarily her child and family members (Fisher *et al.*, 2019). Numerous factors may influence women's experiences related to childbirth, including age, social position, ethnic background, parity; prenatal education and awareness; internal (maternal) and external (societal) expectations; the experience of control during childbirth, pain, the mode of delivery, the extent

¹² This chapter is based on the article 'Udvari, O. (2023) 'Felmérő szakirodalmi áttekintés a szülés körüli anyai tapasztalatok és a társadalmi-gazdasági tényezők közötti kapcsolatáról az OECD-országokban', *Demográfia*, 66(2–3), pp. 115–142. Available at: <https://doi.org/10.21543/Dem.66.2-3.1>.' The article was translated using an AI-based translation tool and was subsequently revised by the author.

of medical interventions, the support provided by professionals and the partner, the duration of labour, and the birth environment (Baas *et al.*, 2017).

Childbirth experience has been proven to have both short- and long-term effects on the health and well-being of women and their families; therefore, among others, the World Health Organisation (WHO) also emphasises the importance of a positive childbirth experience (WHO, 2018). According to research, positive childbirth experiences may promote self-empowerment and a sense of achievement following birth. In contrast, women who perceive their childbirth experience as negative or traumatic often experience persistent and acute symptoms, as well as short- or even long-term consequences (Niebler *et al.*, 2016).

A negative childbirth experience increases the risk of postnatal mental health disorders, including social withdrawal, anxiety, postpartum depression, and post-traumatic stress disorder (PTSD). It may also affect bonding with the infant, reduce the likelihood of breastfeeding, and in certain cases lead to the postponement or avoidance of subsequent pregnancies (Viirman *et al.*, 2022; Gottvall and Waldenström, 2002).

When assessing general experiences, most studies estimate the prevalence of negative childbirth experiences to be around 10%. Women reporting negative experiences frequently describe a lack of sense of control, pain, feelings of helplessness, increased medical interventions, a sense of loneliness and lack of support, as well as inadequate information related to childbirth (Heys *et al.*, 2021; Niebler *et al.*, 2016). Previous research has identified unemployment, single motherhood, and smoking as factors that increase the likelihood of a negative childbirth experience. In addition, the mode of delivery and certain interventions – such as induction of labour, epidural anaesthesia, unplanned or emergency caesarean section, postpartum haemorrhage, perineal tear, as well as hospital events affecting the infant, for example transfer of the newborn to an emergency unit – may also increase the likelihood of a negative experience (Viirman *et al.*, 2022).

Earlier research findings have revealed significant associations between perinatal experiences and socio-economic factors. Women with low socio-economic status and their children are more exposed to poorer maternal and perinatal outcomes, as well as to higher risks of postpartum depression, preterm birth, low birth weight, stillbirth, and neonatal mortality (Vedeler *et al.*, 2023).

However, the relationship between socio-economic factors and women's experiences related to childbirth and the perinatal period is still considered an insufficiently explored area. The present scoping review aims to explore the associations between socio-economic factors and perinatal experiences in OECD countries, based on English-language scholarly articles

published in the past ten years. The review was guided by the following main research question: what relationship exists between perinatal experiences and the mother's socio-economic position?

The scoping review focuses not only on the event of childbirth itself but also on the preceding period (prenatal period, e.g., pregnancy, antenatal care), and the subsequent (postnatal) period and its effects, which we have described using the term perinatal. Furthermore, in the formulation of the research question – and thus later during the search process – the appearance of experiences as an analytical perspective was of particular importance. This primarily referred to the experiences of women awaiting childbirth or those who had already given birth, but was not limited to this; consequently, the experiences of healthcare professionals, family members, or children could also come into the focus of the review. The present review is limited exclusively to studies conducted in OECD countries.

In line with all of the above, the review focuses on the relationship between women's socio-economic background and perinatal experiences in English-language scholarly articles dealing with OECD countries and published in the past ten years.

3.2. Methodology

The present study applies the methodology of a scoping review (Moher *et al.*, 2019; Peters *et al.*, 2015). This type of literature review provides an opportunity to map a given topic by using less specific, more general research questions. Its aim is therefore not identical to that of a systematic literature review (systematic scoping review), which, guided by a specific and narrowly defined question, seeks to conduct a comprehensive analysis based on strict inclusion and exclusion criteria. Instead, the purpose of a scoping review is to draw a kind of “map” of the research and studies conducted in a given field according to predefined aspects (Kutrovátz *et al.*, 2018; Szalma *et al.*, 2023).

In contrast to the most widespread methods of literature reviews, such as meta-analysis, which deals exclusively with quantitative results, or meta-synthesis, which focuses solely on qualitative findings and on summarising them in order to formulate new results, the scoping review allows for the parallel and joint synthesis of studies and literature based on different methodologies, as well as for the comparison of their proportions and approaches.

In summary, the aim of a scoping review is to map the existing literature on a given topic by identifying and summarising various findings. In many cases, an additional goal is to clarify the main and most frequently used key concepts of the given topic and to indicate the most commonly applied methodologies. Furthermore, a scoping review provides an

opportunity to identify potential gaps and to formulate future research directions, and it can also be used as a preliminary study for other types of literature reviews (Szalma *et al.*, 2023).

The literature of three databases, Scopus, Web of Science, and PubMed, was reviewed based on a predefined keyword search. In determining the search terms, two pairs of concepts were designated, with the aim of maximising the number of results by covering their content as broadly as possible through the use of various synonyms. Prior to establishing the final keywords, trial searches were conducted by combining the keywords in different formations and with different focuses; through the refinement of these, the search terms ultimately applied were obtained. The search was conducted in the titles and abstracts of the articles.

The search terms consisted of the phrases ‘childbirth experiences,’ ‘childbearing experiences,’ ‘maternal experiences,’ ‘pregnancy experiences,’ ‘socio-economic status,’ ‘social class,’ ‘economic status,’ and ‘social status.’ The keywords were combined using the connectors ‘OR’ and ‘AND.’

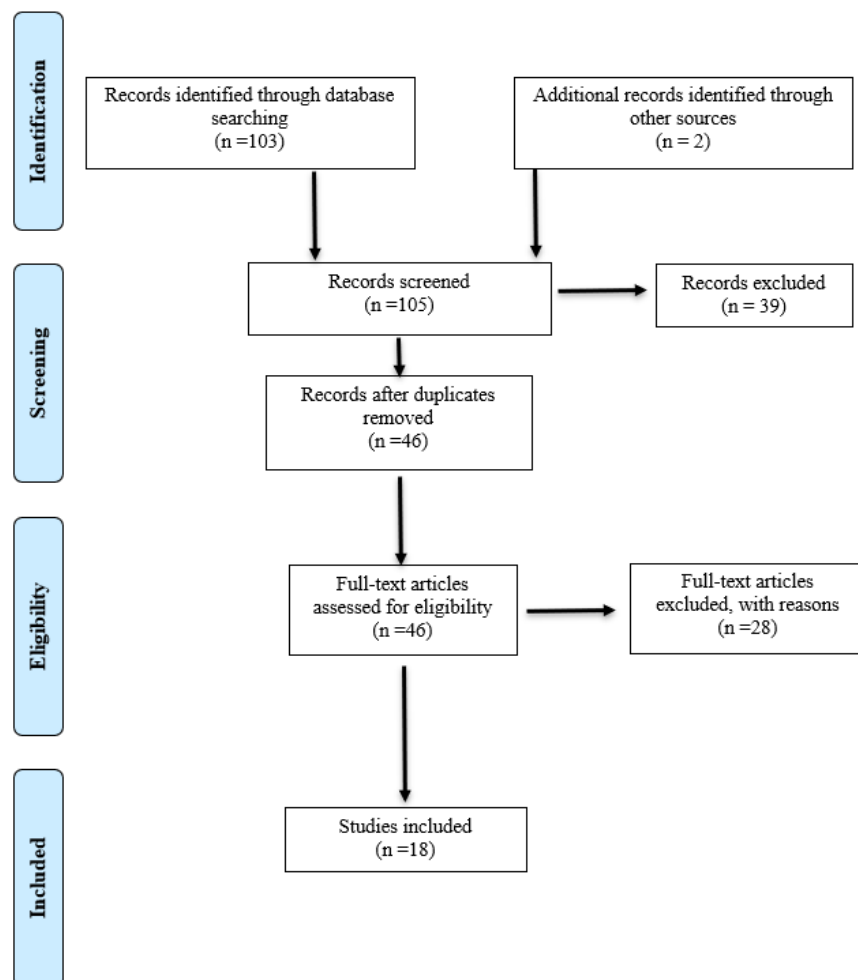
In addition to the defined keywords, the search was carried out by specifying further criteria: English-language journal articles published between 2013 and 2024 were included. Restricting the search by disciplines was not part of the search criteria; therefore, heterogeneity of scientific fields could appear in the results, as could their methodological diversity. During the further selection process, I considered whether the articles identified on the basis of these criteria fell within the scope of the research question and were geographically appropriate. After reading the abstracts – and, where necessary, the full texts – I decided whether a given study fully met all the criteria of the review.

It is also important to address the limitations of the search and selection criteria. The search terms and codes are not perfect, and the search and selection criteria have a number of constraints, which may reflect potential bias stemming from researcher positionality. The present study focuses exclusively on OECD countries, which largely coincide with the category of the “Global North” or “developed countries.” However, examining the research question formulated here is also particularly important in regions outside “developed” or “Western” societies. Although the territorial and social focus of the present article is specific and thus presents a narrowed topic, which is not in contradiction with the methodology of a scoping review, this focus may be expanded and diversified in future literature reviews.

The search conducted in the three databases yielded a total of 103 results. After reviewing the abstracts, 64 relevant studies consistent with the research question remained.

Following the removal of duplicates, this number was further reduced to 44 articles. The next step was the implementation of the geographical scope criterion, based on the reading of the abstracts and, in many cases, the full texts, as a result of which 16 articles were selected for inclusion. An additional two articles were identified through the main reference points of the primary results and were therefore added as supplementary inclusions. Consequently, the final number of articles included in the review was 18 ([Figure 1](#)).

Figure 1. PRISMA flow diagram for the scoping review process



Source: Author's own compilation based on the PRISMA 2009 flow diagram

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and MetaAnalyses: The PRISMA Statement. PLoS Med 6(6): e1000097.
doi:10.1371/journal.pmed1000097

(For more information, visit: <https://www.prisma-statement.org/prisma-2020-flow-diagram>)

Regarding the main methodological distribution of the included articles, quantitative analyses were in clear majority ($n = 10$), followed by purely qualitative studies ($n = 6$), while the remaining studies employed mixed methods ($n = 2$). In terms of geographical distribution,

the vast majority of the research was conducted in North America (eight in the United States and four in Canada), while the remaining six studies were linked to various European countries. As filtering by discipline was not part of the selection criteria, studies from the fields of sociology, anthropology, and neuropsychology, as well as from their interdisciplinary areas, were also included in the review.

3.3. Overview of the studies

Before presenting the overview of the articles, it is important to make a conceptual digression in order to synthesise the key concepts, as differing linguistic codes, abbreviations, and healthcare systems operating differently across fields or regions may carry different meanings or may be more difficult to grasp in their local context.

The two pairs of concepts indicated in the research topic and question – namely socio-economic factors, and perinatal experiences – appeared with different definitions and content in the individual articles. Various factors were included in different studies to describe and capture socio-economic position, making it difficult to identify a single, unified meaning. The main factors applied included socio-economic status (SES) and socio-economic position (SEP). In the present review, all these factors function as broad umbrella terms and as synonyms of one another.

Beyond socio-economic factors, such as income level or educational attainment, ethnicity and race were not examined as separate research subtopics in the studies, but were discussed as part of the socio-economic umbrella concept. However, in the established literature an intersectional approach was typical, that is, the consideration of social and economic (class) position, ethnicity or race, marginalised or minority status, and, self-evidently, the joint consideration of these dimensions. An intersectional approach was particularly characteristic in cases where the focus was on inequalities and differences in birth outcomes and childbirth-related experiences observed between different socio-demographic groups.

Perinatal experiences can be divided into three main periods from the perspective of the review and its structuring: the period preceding childbirth, childbirth itself, and the period following childbirth. The period preceding childbirth, the prenatal period, that is, the immediate period before birth largely coinciding with pregnancy, which may also include the mother's even earlier experiences, such as childhood socio-economic position, migration or psychological history, or previously experienced discrimination. The period of childbirth refers specifically to the shorter phase of labour and birth. The postnatal period again covers a broader

time interval: the postpartum, that is, the immediate period after birth constitutes its larger part, but this category may also include longer-term effects, such as certain developmental consequences. The grouping of the articles and the division of the review into subsections followed this classification, that is, according to which of the three designated main periods a given study placed its central research focus and investigation. It is important to note that individual studies may in some cases extend across several periods and may include factors from different phases; therefore, they are not exclusively assigned to a single period, and the categorisation was carried out in accordance with the primary focus of the research question.

3.3.1. The prenatal period

The articles addressing the period preceding childbirth can be divided into two further main groups: studies examining the impact of the mother's prior history – mental and socio-economic – on childbirth and birth outcomes, and articles analysing the state of antenatal care and related healthcare services.

The effects of the mother's experiences before and during pregnancy were examined from a broader natural science perspective, specifically from the fields of neuropsychology and developmental science, in two American articles. In a study investigating 205 mother–child pairs belonging to minority racial and ethnic groups, it was found that among mother–offspring pairs with medium and high socio-economic status, maternal experiences of discrimination were associated with lower epigenetic age acceleration (EAA), that is, slower biological development in the offspring in early childhood (age 3) and middle childhood (age 7) compared to those who had not experienced discrimination (Laubach *et al.*, 2024). Another study, which examined the effects of factors related to discrimination during pregnancy and acculturation on fetal and infant development in a sample consisting predominantly of Spanish-speaking adolescent mothers, concluded that maternal prenatal discrimination and acculturation influence the brain functioning of the developing child (Spann *et al.*, 2024).

A 2018 study also addressed the consequences of impacts affecting the parent, examining the relationship between maternal intragenerational socio-economic mobility and preterm birth (Tian *et al.*, 2018). This mixed-methods study conducted in the United States analysed the association between maternal social mobility (from childhood to adulthood) and the risk of preterm birth, specifying their heterogeneity according to race and ethnic background. Tian and colleagues found that upwardly mobile women had a lower likelihood of preterm birth compared to those who remained in a low socio-economic position. The research was based on the results of a cohort study conducted in Michigan, which consisted of

a socio-economically diverse sample. In the study carried out between 1998 and 2004, 3,019 pregnant women participated, who were enrolled in the Prospective Pregnancy Outcomes and Community Health (POUCH) study between the 16th and 27th weeks of their pregnancy. The women took part in a structured personal interview, during which they completed a self-administered questionnaire collecting information on demographic characteristics, lifestyle, psychosocial factors, medical history, and health status.

In the sample, 11.1% of pregnancies ended in preterm birth, and approximately one quarter of the women were Black. The authors found that women with both low childhood and low adult socio-economic position had the highest risk of preterm birth, while pregnant women who experienced social mobility had a lower probability of preterm birth. Overall, the results of the study support the researchers' preliminary hypothesis that improvement in women's socio-economic position from childhood to adulthood may improve pregnancy outcomes.

Three articles dealt with the period immediately preceding childbirth, that is, the prenatal period, through three different, specific topics. A 2014 study conducted in the United Kingdom aimed to gain a deeper understanding of the reasons why some women first present for antenatal care late (at the 20th week of pregnancy or later) (Haddrill *et al.*, 2014). The official recommendation in the United Kingdom is that all pregnant women should attend their first antenatal appointment by the 10th–12th week of pregnancy, and that all screening should be completed before the 21st week of gestation (Haddrill *et al.*, 2014, p. 2).

With regard to antenatal care, it is widely acknowledged that it contributes to better pregnancy outcomes, as late utilisation – which is closely related to the issue of access – is associated with an increased risk of maternal, fetal, and infant mortality, as well as morbidity. This phenomenon affects various minority and ethnic groups to a greater extent, since, according to the findings of previous studies, those who present late for antenatal care typically come from socially excluded groups (e.g. minorities, adolescents, individuals with low educational attainment).

In order to answer the research question, the authors chose a qualitative methodology. In developing the sample, they aimed for diversity, seeking to reach women with different social and occupational backgrounds, and also encouraged the inclusion of “vulnerable groups” (e.g. teenagers, newly arrived migrants, women with substance use, or those with learning difficulties). The final sample of twenty-seven participants included twenty-one White British women, while six belonged to other ethnic groups; four teenagers under the age of 18 and three women with learning disabilities were included in the study. The semi-structured interviews were interpreted by the authors using thematic analysis.

The study identified three main groups: “the less knowledgeable,” “the knowledgeable,” and “the delayers.” The group of “the less knowledgeable” included those who entered antenatal care late due to a lack of information. Many of the interviewed women reported that for weeks or sometimes months they did not know that they were pregnant, which delayed their access to care. Those belonging to the “knowledgeable” group were aware that they were pregnant but did not access early care. Among these women, three main themes were observed: avoidance, postponement, and delay caused by others. While women who avoided care did not plan to use it, those who postponed care intended to access it “at some point” in the future. Delay caused by others referred to late access due to the healthcare system or relatives. The group of “delayers” were generally aware relatively early that they were pregnant and were willing to participate in antenatal care in a timely manner; however, due to other reasons (e.g. institutional error, lack of knowledge about the healthcare system and the booking process), they registered late.

The issue of late attendance, as well as the complete omission of care, was examined by Adeniyi and colleagues (2020) in a specific area of antenatal care. Dental screenings constitute an important subfield of antenatal care. Maternal oral hygiene and dental check-ups during pregnancy are significant due to their potential associations with fetal health, pregnancy outcomes, and the occurrence of childhood oral diseases. However, many pregnant women, especially those in socially disadvantaged situations, such as immigrants, individuals of low social class, and homeless women, face difficulties in accessing dental healthcare services. This can often be explained by the fact that these services are difficult for them to afford. In addition to affordability, further factors hinder access to dental care, such as insufficient knowledge about oral hygiene, the availability of service providers, and geographical location.

The research by Adeniyi and colleagues examined knowledge and perceptions related to dental healthcare during pregnancy in a targeted sample of socially disadvantaged pregnant women and recently delivered mothers living in Surrey (British Columbia, Canada). The qualitative exploratory study was based on the analysis of focus group discussions conducted with seventeen women who received care at a local maternity clinic serving a diverse, socially disadvantaged population. Participants included in the study had to meet at least one of the following criteria: low income, newly arrived immigrants or refugees, homeless or at risk of homelessness, formerly incarcerated, or substance users. Participants were recruited by the clinic staff.

During the thematic analysis, the researchers identified three main themes: (1) knowledge about the importance and value of oral hygiene during pregnancy, (2) experiences

related to dental healthcare, and (3) dental services provided for socially disadvantaged pregnant women. Out of the seventeen participants, only three had undergone a dental examination during their pregnancy. Participants considered dental care to be expensive and reported that one of the main barriers to accessing regular care was limited or completely lacking health insurance coverage (the role of which also emerges in a later study). Fear of dental treatment, as well as previous traumatic experiences related to care, were also mentioned as important hindering factors. The feeling of stigmatisation by healthcare workers was also mentioned by participants in the study (e.g. due to lack of insurance), and the geographical location of dental practices and their difficult accessibility also emerged as barriers.

The feeling of experienced stigmatisation is addressed by several of the included studies. An interesting dimension of stigma and treatment related to care was discussed in an essay, and in connection with it an included study on which the essay itself was based. McHugh's essay commentary (2019), written in response to the original 2019 article by Ward and McPhail, was included in the review through the keyword search results. The topic of these articles is the phenomenon of fat bias and blame in reproductive healthcare. Through a review of the literature on the subject, Ward and McPhail explore the associations that previous research has identified between the stigma of fat shaming and negative health outcomes. From the perspective of critical thinkers, the (Western) social assumption concerning body weight and body size is in line with the neoliberal approach to health, as it conceives the body as being under the direct control and full agency of the individual, who therefore has both the opportunity and the obligation to change a "non-ideal" body. Overweight individuals are surrounded by stereotypes (lazy, irresponsible, unmotivated, unaware of "proper" health behaviour, etc.) that follow from this conception.

A vicious circle emerges: stigmatising mechanisms may lead to health deterioration and the avoidance of healthcare through psychosocial stress, which in turn may cause further stigma and stress. Turning to the situation of pregnant women, Ward and McPhail state that pregnant women face a specific type of inequality based on medical beliefs concerning the association between fetal risk and maternal body weight. In these discourses of "mother blaming," almost all health problems experienced by fetuses and children tend to be attributed to mothers' behaviour, or even to their genetics. Women whose bodies do not approximate the ideal body image reported stigmatising experiences of care in numerous areas of reproductive healthcare. Many participants in the studies highlighted that they were immediately labelled as "high risk." These risks were often presented to participants not as risks but as certainties. Medical consultations frequently focused on body weight (and weight loss) rather than on the woman

herself, which led to the depersonalisation of care. The medicalisation of increased body weight is also characteristic, conceptualised as a “disease” within reproductive healthcare.

McHugh’s commentary further develops the conclusions and recommendations of Ward and McPhail, which emphasise the need to change the attitudes of healthcare professionals and highlight the importance of training on this topic (McHugh, 2019). The elimination of fat shaming against women should be incorporated into the guidelines of reproductive healthcare practice. The author recommends sensitivity training and suggests that students and teachers in healthcare education, as well as professionals working in healthcare, should become familiar with the comprehensive literature on body weight and maternal obesity.

Access to care and its quality in a specific period, during the COVID-19 pandemic, were examined in an American study published in 2022 (Collart *et al.*, 2022). Numerous effects of the pandemic on healthcare services have been investigated; however, according to Collart and colleagues, the impact of visitor restrictions on antenatal care remained unknown for a long time. Therefore, in their research conducted in 2020, they sought to explore how visitor restrictions affected women’s experiences of antenatal care and their perceptions of the quality of healthcare.

Participants in the study were women aged 18 years or older, English-speaking, with an intrauterine pregnancy, and receiving outpatient obstetric care within the Cleveland Clinic Healthcare System. Recruitment took place between May and July 2020. During this period, restrictions in local outpatient antenatal care fluctuated between allowing zero or one accompanying person. Forty semi-structured interviews were conducted with the participants. The average age of the women included in the study was 32 years.

The qualitative thematic analysis identified three main themes. The first theme addressed concerns and experiences related to the actual absence of the designated primary support person (in most cases the partner) during antenatal care. The second theme revealed that for some women the absence of the partner reduced the expected support, and these experiences did not materialise. The third theme involved concerns about access to information related to antenatal care and informed decision-making, which arose when the partner was not present and there was no opportunity for joint, considered decision-making.

Based on the narratives of the participants, it became clear that the presence of a support person (spouse, partner, family member, or friend) during antenatal care was of particular importance to them, and involving this person in decision-making appeared among the most important aspects. The presence of the support person was also considered important in order

to have someone who could assist in guiding conversations and asking questions, enabling joint decision-making on specific issues. As a potential long-term effect of the restriction on accompanying persons, women expressed concerns that the partner might find it more difficult to bond with the child after birth. Furthermore, women were increasingly worried about their mental health, emphasising the possible increase in the occurrence and severity of postpartum depression among pregnant women during the pandemic.

3.3.2. Childbirth

The articles focusing on childbirth – and primarily on its outcomes, experiences, perceptions, and their socio-economic determinants – consist mainly of large-sample studies in the review, in addition to which one small-sample qualitative study was also included.

The results of a study published in Norway in 2023 support that there is a close relationship between women's overall childbirth experiences and socio-economic factors (Vedeler *et al.*, 2023). Women who reported lower socio-economic status (lack of higher education, being unemployed, students, or having a low subjective standard of living), were not married or did not live with a partner, were more likely to experience a negative childbirth experience than those with higher status (Vedeler *et al.*, 2023). In their research, Vedeler and colleagues conducted a secondary analysis of the Norwegian data from the second version of the Babies Born Better (B3) survey.

The B3 survey is an international online questionnaire that examines women's experiences related to obstetric care. The survey provides both quantitative and qualitative data. Using a five-point Likert scale, women were asked about their overall experiences related to labour and childbirth, while socio-economic status was measured on the basis of educational attainment, employment status, and subjective standard of living. The study sample consisted of 8,317 women who gave birth in Norway between 2013 and 2018. The average age was 30 years, and 92.2% of the women were born in Norway. Overall, 11.7% of respondents reported a negative childbirth experience ("mostly a bad experience" or "mostly a rather bad experience"). The likelihood of a negative childbirth experience was higher among women without higher education, those who were not married or not cohabiting with a partner, as well as among unemployed women and those still studying. Based on the main research question of the qualitative analysis (How do women who report an overall negative childbirth experience describe their experiences?), three themes emerged during the authors' reflexive thematic analysis: (1) care without compassion: lack of sensitivity and empathy, (2) impersonal care:

the feeling of objectification, and (3) critical situations: feelings of uncertainty and loss of control.

The fundamental need for staff to approach women with empathy and compassion was not met for those who experienced their childbirth negatively. One of the reasons for this was the condescending attitude and behaviour of healthcare professionals, which caused a sense of disempowerment and loss of dignity. In many cases, this appeared in the responses as a structural problem, according to which the “system” does not prioritize or recognize women’s emotional needs and the psychosocial impact of women’s experiences. The failure to acknowledge childbirth as a profoundly personal experience left women with a sense of objectification. In the responses, it was mentioned that women felt they were treated like animals or objects, that staff talked over their heads, or even forgot about them. The structural aspect also emerged here, suggesting that the lack of necessary care could be related to staff shortages, lack of resources, and the way care is organised. Experiencing severe medical complications or emergencies appeared emotionally burdensome and frightening to the respondents. Trust in professionals was a key factor, as in its absence critical situations could become even more traumatic for women giving birth.

A Swedish cohort study (Viirman *et al.*, 2022) examined the risk factors of negative childbirth experience broken down into three different periods; before pregnancy, during pregnancy, and at the time of childbirth. The study used data from the Swedish Pregnancy Register on births between 2013 and 2018. The Swedish Pregnancy Register currently covers more than 90% of all births in Sweden. The register contains demographic, reproductive, and maternal health data collected from the first antenatal care visit. In their research, Viirman and colleagues included women giving birth to their first child, as they are at the beginning of their reproductive life, and a negative childbirth experience may therefore affect subsequent pregnancies and births. The final sample consisted of 80,482 women (from which women who underwent planned caesarean section were excluded). The majority of the women were aged 20–34 years, were born in high-income countries, had at least secondary education, were employed, and lived with the father of the child.

The prevalence of negative childbirth experience was 8.4%. The authors found that significant risk factors for negative childbirth experience were maternal age over 35 years, obesity, and poor self-rated health (SRH). Poor SRH was the only pre-pregnancy factor that remained associated with negative childbirth experience after adjustment for pregnancy- and birth-related factors. Psychiatric care during pregnancy and fear of childbirth were both

associated with negative childbirth experience. The highest risk factor for negative childbirth experience was unplanned caesarean section performed under general anaesthesia.

Originating from a low–middle or low-income country, as well as low educational attainment, provided protection with regard to negative childbirth experience. These findings are somewhat surprising, considering that fear of childbirth and unplanned caesarean section are more common among foreign-born pregnant women in Sweden. One explanation offered by the authors is that women from low-income countries take different aspects into account when evaluating childbirth experience than women born in Sweden. Another possible explanation is the language barrier in completing the questionnaire, as no information was available on the Swedish language proficiency of the sample members.

In a nationwide study conducted in the Netherlands, 8% of the participating women (192 women) experienced “less than good” obstetric care (Baas *et al.*, 2017). In their investigation, Baas and colleagues did not examine satisfaction with the process of childbirth itself, but specifically focused on experiences related to the care provided. The data for the study were derived from the Dutch DELIVER cohort study, which was carried out between September 2009 and April 2011. During the research, three questionnaires were administered at different time points: one in the early prenatal period (around the 20th week of pregnancy), one in the later stage of pregnancy (around the 34th week), and one approximately six weeks after birth. During completion, participants provided information on their demographic and economic background characteristics (age, parity, educational attainment, employment status, socio-economic position, marital status, ethnic background), as well as on whether the pregnancy was planned or unplanned. In the course of data collection, 7,685 women completed at least one questionnaire (response rate 53%), of whom 4,146 completed all three questionnaires; ultimately, according to the criteria established by Baas and colleagues (uncomplicated birth), 2,377 women were included in their study. The researchers measured experiences of obstetric care provided during childbirth using a summary evaluation scale (1–10). By dichotomising this scale, they created two groups: “less than good” care (rating 1–7) and “good or the best possible” care (rating 8–10).

A total of 2,185 women (92%) evaluated their birth as “good or the best possible,” while the others rated it as “less than good.” The study revealed that among women who experienced “less than good” care, unplanned caesarean section, interventions during labour, and lower levels of control during the dilation and pushing phases were significantly more frequent than among those who rated their care more positively. A significant association was found between control during the dilation and pushing phases and the experience of “less than good” care.

Two included articles addressed the issue of childbirth experiences through secondary analysis of data from the Canadian Maternity Experiences Survey (MES). The Canadian Public Health Agency, in cooperation with Statistics Canada, conducted the MES as part of the perinatal surveillance system. The survey contained more than 300 questions concerning pregnancy, childbirth, and the postnatal period. The target population consisted of mothers aged 15 years or older who had given birth in any Canadian province between 15 February and 15 May 2006, or between 1 November 2005 and 1 February 2006, and who were living with their child at the time of the survey.

A study published in 2015 based on the survey found that the higher a mother's socio-economic position, the better the maternal and child health indicators (Daoud *et al.*, 2015).

Another study published in 2016 aimed to assess the prevalence of negative childbirth experience among Canadian women and to identify risk factors associated with negative childbirth experience (Smarandache *et al.*, 2016). Negative childbirth experiences were based on mothers' self-reports, which were derived from a combined interpretation of their overall experiences of labour and childbirth. The independent variables included mothers' demographic data, health characteristics, and the characteristics of pregnancy and childbirth. On average, 9.3% of Canadian mothers rated their childbirth experience as somewhat negative or very negative, with the highest averages reported in Western Canada. Among mothers, negative experiences of labour and childbirth were significantly associated with older age, poorer self-rated health, domestic violence, antenatal care, and delivery by caesarean section. Mothers over the age of 30 were twice as likely to report negative experiences as younger mothers. The most significant childbirth-related characteristic associated with negative labour and childbirth experiences was the type of delivery (i.e. vaginal or caesarean section). Several potential predictive characteristics did not contribute to negative childbirth experience, such as smoking, alcohol consumption, and drug use. Participation in antenatal preparation classes proved to be one of the most surprising factors, which was significantly associated with negative childbirth experiences. In the sample, attendance at prenatal courses increased the risk of negative labour and childbirth experience, the more detailed interpretation of which requires further investigation in the future.

In addition to the large-sample quantitative studies, however, one qualitative study focusing on the lived experience of childbirth was also included in the review. A 2016 study conducted in one of the "new growth areas" (NGA) of the United States focused on the childbirth experiences of Latina women. The research examined how women experience childbirth, what the most important factors are in the development of positive or negative

childbirth experiences, and what role health insurance status plays in childbirth experience. In establishing the relevance of their research, the authors point out that the Latin American population currently constitutes the largest minority in the United States, and that new immigrants often move not to areas with high immigration rates but to places where the number of Latinos is lower. These are the so-called new growth areas. However, in terms of infrastructure and administration, these areas respond slowly to the potentially specific needs of local communities, and insufficient knowledge of the healthcare system, communication barriers, and social isolation negatively affect the health of Spanish-speaking people living in NGAs, leading to conditions that may promote poor physical and mental well-being. In addition, another important focus of the study was the role of health insurance, as it is well known that Latin Americans have the highest proportion of uninsured individuals among any group in the United States. This is particularly important because insurance coverage leads to better health outcomes, whereas uninsured individuals may experience stigmatisation and poorer treatment.

The research employed a qualitative methodology; between January and March 2011, members of the research team conducted semi-structured interviews with ten women. Half of the sample of ten participants (women over 18 years of age, who had immigrated from Spanish-speaking countries and had given birth in Allegheny County within the previous 12 months) had health insurance. The questions addressed experiences related to childbirth, including hospital experiences, interactions with care providers, and issues related to women's control during labour, delivery, and the postnatal period.

The results showed that the women participating in the study unanimously agreed that childbirth had been an indescribably positive event for them, as it was the process through which they came to know their children ("it was worth all the difficulties" – "vale la pena"). The perceived sense of control, the support of loved ones, and the relationship and communication with healthcare providers also played an important role in shaping the childbirth experience. Despite the existence of common elements between insured and uninsured women, important differences were identified.

Four out of the five insured participants reported that they exercised full control over the decisions made during labour and childbirth. In contrast, the five participants without insurance found it more difficult to speak about having control. In addition, none of the uninsured participants reported that family members had travelled to be with them to provide support ('familismo'), whereas four insured women had their mothers, who lived elsewhere, present. Regarding their overall experiences, all participants reported that most healthcare

providers were attentive during interactions ('personalismo'); however, eight of them reported at least one problem with a healthcare provider while they were in the hospital.

Overall, the authors concluded that the childbirth experience is greatly influenced by health insurance status, and the results indicated that the relationship between insurance status and the evaluation of care was closely associated with educational attainment and English language proficiency; furthermore, insured participants occupied a higher social status in the social hierarchy than uninsured participants.

3.3.3. The postnatal period

All four articles included in the review that addressed the period following childbirth focused on the postpartum period and maternal mood disorders, examining them using quantitative methods. Among these, postpartum depression (PPD) or postnatal depressive symptomatology (PNDS) appeared, which we refer to using the overarching concept of postnatal depression, and post-traumatic stress disorder (PTSD) can also be classified within this category.

Postpartum depression is a type of mood disorder that may occur in the period following childbirth. Its characteristics and symptoms include anxiety, exhaustion, sleep and eating disorders, feelings of emptiness, and problems with self-esteem. Postpartum depression makes it difficult for the mother to care for herself and her child. The symptoms of PPD have serious consequences for mothers, as suicides account for 20% of maternal deaths after childbirth among those suffering from postpartum depression (Grisbrook *et al.*, 2022).

In addition to biological and genetic factors, the mother's psychosocial history and personal characteristics also influence the development of postnatal depressive symptoms (Fisher *et al.*, 2019). These include psychiatric history, socio-economic status, the occurrence of previous obstetric interventions, and experiences with healthcare system staff. Depression in medical history is currently the main identified risk factor for PNDS. Stressful life events and obstetric complications also contribute to the increased risk of developing clinically significant PNDS. On the other hand, social and partner support, socio-economic status, maternal personality traits, and differences in infant temperament may function as either risk factors or protective factors (Bales *et al.*, 2023).

Post-traumatic stress disorder (PTSD) is a condition that may develop after exposure to a traumatic event, and its typical symptoms include re-experiencing the traumatic event in the form of flashbacks and nightmares, as well as avoidance reactions, heightened arousal, fear, and concentration difficulties (De Schepper *et al.*, 2016).

Fisher and colleagues (2019) set the objective in their research to identify the possible trajectories of postpartum depression during the 12 months following childbirth, and to determine the main characteristics predicting these courses. Based on these, they developed an algorithm capable of predicting the likelihood of belonging to a specific trajectory. The study was based on the secondary analysis of data from a research project conducted in Pittsburgh. The research involved the identification, diagnosis, and treatment of cases of postpartum depression among women in a metropolitan healthcare centre. During the study, all women were approached during their postpartum hospital stay and were assessed for eligibility for postpartum psychological screening ($n = 27,504$). Women were included in the study if they were at least 18 years of age, spoke English, and had given birth in the designated institution ($n = 15,172$). The final sample ($n = 507$) consisted of women who screened positive for depression according to the Edinburgh Postnatal Depression Scale. The 507 participants were predominantly White and married, and less than half had completed at least college education.

The researchers identified three distinct trajectories of depressive symptoms: (1) gradual improvement, (2) partial improvement, and (3) chronic severe condition. Based on four key factors (e.g., parity, educational attainment, baseline functioning, severity of depression) they were able to predict the type of trajectory with 72.8% accuracy. Compared to those belonging to the second and third types, women in the first group were significantly more likely to have higher educational attainment, to be raising fewer children, and to be less likely to have comorbid anxiety disorders.

Findings regarding the relationship between caesarean sections and postpartum depression are mixed (Carter *et al.*, 2006, cited in Grisbrook *et al.*, 2022). One possible reason for this is that earlier studies did not necessarily distinguish between planned and unplanned, emergency caesarean sections. Reflecting on this, a study conducted in Canada examined the association between different types of caesarean section and postpartum depression, taking PTSD symptoms into account (Grisbrook *et al.*, 2022). For this purpose, a secondary analysis of data from the Alberta Pregnancy Outcomes and Nutrition (APrON) longitudinal cohort study was carried out. The primary aim of the APrON study was to collect data on the mental health and nutrition of mothers and children, as well as on children's neurodevelopment. Pregnant women were eligible to participate if they lived in one of two major cities in Alberta, Canada (Calgary and Edmonton), were over 16 years of age, were less than 27 weeks pregnant at the time of enrolment, and were able to complete the questionnaire in English. The main findings show that emergency caesarean section is indirectly associated with postpartum depressive symptoms through PTSD symptoms. Mothers who delivered by emergency or unplanned

caesarean section had almost half a point higher PTSD scores compared to mothers who underwent planned caesarean section, which represents a significant difference. Furthermore, higher PTSD scores were associated with more severe postpartum depressive symptoms in the three months following childbirth. The type of caesarean section showed no direct association with postpartum depression; however, emergency caesarean section demonstrated an indirect association with postpartum depressive symptoms through PTSD symptoms.

The prevalence of PTSD related to the postnatal period was examined by De Schepper and colleagues in a Flemish sample (De Schepper *et al.*, 2016). They aimed to investigate how sociodemographic factors (e.g. age, socio-economic status, educational attainment, religion) and obstetric risk factors (e.g. mode of delivery, epidural analgesia, experiences during labour and birth), as well as factors related to obstetric care (e.g. attention of the obstetric team, information provided to the mother), influence the development of childbirth-related PTSD. In the study conducted between January and June 2013, women were recruited from 13 different obstetric units during the first week after giving birth. Of the 420 women invited to participate, a total of 340 agreed. Of these 340 women, 229 (67%) also took part in the second phase of the study. The average age of the women was 30 years, more than half were married, and 4.7% were single. Almost half of the women had higher education, the majority were of Catholic faith, and nearly one quarter had a family net income below 2,500 euros. Nearly two thirds of the women had a spontaneous vaginal delivery and 22% had a caesarean section, of which 39% were unplanned caesareans.

The research team observed PTSD symptoms in 22–24% of women during the first week after childbirth, and in 13–20% of women six weeks later. The risk factors for the development of PTSD symptoms in the postnatal period were the following: perceiving the birth as traumatic, family income below 2,500 euros, Islamic faith, psychological problems in medical history, and giving birth in a hospital with a neonatal intensive care unit. Six weeks after childbirth, the experience of traumatic birth, family income below 2,500 euros, childbirth with complications, and psychological problems proved to be factors associated with PTSD symptomatology. Protective factors included women feeling that they were able to maintain control during childbirth, as well as being able to ask questions of the midwife during labour.

In their study, Bales and colleagues (2023) explore the associations between a wide range of maternal, infant, and environmental factors present before and after childbirth and the severity of postnatal depressive symptomatology during the two months following birth. The data for the study were derived from the French national representative ELFE (Étude Longitudinale Française depuis l'Enfance) cohort study, which aims to monitor the

development of infants and children. Data were collected from women who gave birth in 2011 in 349 obstetric hospitals randomly selected from among 544 public and private maternity hospitals in metropolitan France. A total of 18,329 mothers were included in the study. In the first wave of data collection, information was recorded by midwives during the women's hospital stay based on medical records and personal interviews with the mothers. The second wave of data collection took place by telephone between the sixth and eighth weeks after childbirth, in which 90% of the enrolled families participated.

The research discussed here included only those mothers in the analysis who were living with the child's father and for whom no data were missing regarding the variables under study. In the research, the authors adopted Milgrom's biopsychosocial model as a theoretical framework, which, in analysing postpartum depression, emphasises the importance of protective factors and provides an opportunity to explore direct and indirect associations between maternal and environmental factors in the periods before and after childbirth (Bales *et al.*, 2023, p. 3). Regarding maternal and environmental pre-birth variables, the lack of emotional support from the partner during pregnancy, consultation with a mental health professional before pregnancy, family financial difficulties, psychological stress before childbirth, and experiencing pregnancy as difficult were positively and directly associated with the severity of depression in the two months following birth.

The results of the study highlight the crucial role of support provided during the perinatal period, particularly support from the partner. In addition, it should be emphasised that the quality of the relationship during pregnancy is more important than current partner support after childbirth, and may exert a direct protective effect on the mother's emotional stability in the postnatal period. It was also established that the presence of mental health problems in medical history is among the main risk factors for postpartum depression. The mediating effect of perceived lack of support before and after childbirth, psychological stress before birth, and the difficult experience of pregnancy highlights the central role of the quality of perinatal support and psychological factors among women who are socio-economically vulnerable.

3.4. Summary

The present scoping review examined journal articles published in English over the past ten years on the topic of socio-economic factors and perinatal experiences, focusing on OECD countries, based on the results of three databases. The guiding research question (what relationship exists between perinatal experiences and the mother's socio-economic position?) was investigated by the 18 reviewed studies in the periods before childbirth, during childbirth,

and in the immediate period following childbirth. The main topics covered by the articles include antenatal care and access to it, the role of maternal social and mental history in perinatal experiences, the analysis of factors that increase or decrease negative childbirth experiences, and the interpretation of maternal mental disorders in the postpartum period in relation to the impact of maternal socio-economic position. The majority of the articles included in the review employed quantitative methodology, in many cases based on secondary analysis of data from large-sample cohort studies.

The articles discussed in the subsection on the period preceding childbirth analyse the impact of the mother's prior history – mental and socio-economic – on childbirth and birth outcomes, as well as the situation of antenatal care and related healthcare services. Diverse and mixed approaches and topics were elaborated: the developmental effects of discrimination experienced by the mother on the offspring (Laubach *et al.*, 2024; Spann *et al.*, 2024), the examination of the relationship between maternal socio-economic mobility and preterm birth (Tian *et al.*, 2018), as well as perceived inequalities in access to and treatment within antenatal care (Adeniyi *et al.*, 2020; Haddrill *et al.*, 2014; Collart *et al.*, 2022; McHugh, 2019; Ward and McPhail, 2019).

With one exception, the studies dealing with the course of childbirth and the factors influencing it all employed quantitative methods. The findings of the reviewed articles support the approximately 10% prevalence of negative childbirth experiences. Research focusing on “less than good” (Baas *et al.*, 2017) or explicitly negative childbirth experiences (Daoud *et al.*, 2015; Smarandache *et al.*, 2016; Viirman *et al.*, 2022; Vedeler *et al.*, 2023) explored which main factors influence more negatively experienced births and which factors prove to be protective against such experiences. The influencing effect of socio-economic factors, after their detailed breakdown into specific components, was demonstrated by all studies, while one qualitative study highlighted the particularly important role of health insurance (Niebler *et al.*, 2016).

All of the articles addressing the period following childbirth focused on maternal mental disorders, postpartum depression, and post-traumatic stress disorder. One study distinguished three trajectories of postpartum depression according to the severity of depressive symptoms (Fisher *et al.*, 2019). Regarding the association between caesarean section and postpartum depression, it was found that emergency, unplanned caesarean section is indirectly associated with the development of postpartum depression (Grisbrook *et al.*, 2022). A study focusing on a Flemish population revealed that traumatic childbirth experience, family income below 2,500 euros, childbirth with complications, and psychological problems were associated

with PTSD symptomatology; at the same time, protective factors included women feeling that they themselves were in control during childbirth and being able to ask questions of the midwife during labour (De Schepper *et al.*, 2016). Bales and colleagues established that one of the most decisive factors in the mother's postnatal emotional stability is the presence of emotional and social support, as well as its quality during pregnancy (Bales *et al.*, 2023).

As a general conclusion, the examined studies indicate that socio-economic factors are significantly associated with perinatal experiences, although the direction and strength of these associations vary across specific dimensions and contexts. A further common point is that the environmental factors of negative childbirth experience were interpreted within a structural framework, and in no case as individual responsibility. In most studies involving healthcare systems, researchers almost without exception highlighted the importance of taking into account potentially differing obstetric care systems, whether within countries, states, or at regional level. Without exception, the studies concluded with research implications and, in many cases, with the formulation of concrete recommendations, which included the emphasis on person-centred healthcare systems, the provision of integrated care, and the importance of training and education aimed at combating prejudice and discrimination.

The present literature review has a number of limitations. Due to the constraints of the search terms and the regional criteria, the database created represents only a narrow cross-section of the defined research field, which, although not in contradiction with the methodology of a scoping review, means that the mapped literature can only be considered as partial results. Future territorial expansion of the search is therefore recommended in order to overcome this limitation, possibly complemented by searches in additional databases. The aim of the present review was to map studies examining the associations between socio-economic factors and perinatal experiences. During the review, it became clear that local investigations of the researched topics and questions should be encouraged; in addition, the postnatal effects on the environment and family members (e.g. fathers) remain under-researched, and the evaluation of prenatal preparations and courses also appears to be an exciting research direction within this field.

4. SOCIO-DEMOGRAPHIC FACTORS, INFORMAL PAYMENTS AND SATISFACTION WITH CHILDBIRTH IN THE HUNGARIAN CONTEXT¹³

Abstract

Objective This study aims to investigate the association between socio-demographic factors and childbirth satisfaction in Hungary, with a particular focus on the role of informal payments. While previous research has extensively examined maternal satisfaction, the specific associations between socio-demographic characteristics and childbirth experiences remain insufficiently explored, particularly in Hungary, where informal payments and dual healthcare system coexist. By addressing this gap, the study seeks to provide a deeper understanding of the factors that shape birth satisfaction.

Methods This study examines satisfaction with childbirth using a representative sample of the Hungarian adult population surveyed between February and April 2024. Descriptive statistics (chi-square test) and factor analysis were applied to understand perceptions of quality obstetric care, including responses from childless women and men (N = 1360). Logistic regression examined socio-demographic predictors of satisfaction with obstetric care among mothers and fathers evaluating their partners' experiences (N = 695).

Results Findings underscore the significance of financial factors in childbirth care. Individuals with lower education levels often consider informal payments and private doctors essential for quality care ($\chi^2 = 18.0$, $p < 0.05$). Factor analysis revealed two key dimensions: financial and competency. Emphasis on financial aspects correlated with dissatisfaction (Financial components, Factor 1: OR = 0.74, 95% CI, $p < 0.05$) while prioritizing competency was linked to higher satisfaction (Competence, Factor 2: OR = 1.54, 95% CI, $p < 0.01$). The percentage of women dissatisfied with their childbirth experience was 13.8%, compared to 6.1% of men.

Conclusion Efforts to reduce reliance on informal payments and enhance equitable access to high-quality obstetric care are critical for improving childbirth satisfaction in Hungary.

Keywords Childbirth satisfaction, socio-demographic factors, informal payments, obstetric care, healthcare inequalities

¹³ This chapter is based on the article 'Udvari, O. and Szalma, I. (2025) 'Socio-demographic factors, informal payments and satisfaction with childbirth in the Hungarian context', *BMC Pregnancy and Childbirth*, 25, article 409. Available at: <https://doi.org/10.1186/s12884-025-07521-3>.' Minor revisions have been made for consistency and clarity within the dissertation.

4.1. Introduction

Childbirth experience and satisfaction have been shown to have short- and long-term effects on the health and well-being of mothers and their families. This is why organisations such as the WHO emphasize the importance of positive childbirth experiences (WHO 2018). Research suggests that positive childbirth experiences can promote feelings of empowerment, achievement, and increased self-esteem following childbirth. Conversely, negative or traumatic childbirth experiences have been associated with adverse outcomes, including postpartum mental health disorders such as postpartum depression, anxiety, and post-traumatic stress disorder (PTSD) (Fisher *et al.*, 2019; De Schepper *et al.*, 2016; Grisbrook *et al.*, 2022). Such experiences may also impact maternal-infant bonding, breastfeeding, and decisions about future pregnancies (Gottvall and Waldenström, 2002; Viirman *et al.*, 2022).

The multidimensional nature of childbirth satisfaction has been widely researched, with findings suggesting it is influenced by various factors, including demographic characteristics, birth preparation, perceived control, pain management, delivery mode, and support from healthcare professionals and family members (Waldenström, 1999; Hochman *et al.*, 2023; Udvari, 2023; Srivastava *et al.*, 2015; Akca *et al.*, 2017). Medical interventions, such as emergency procedures (e.g. high-risk pregnancies) and pain relief, play a critical role in shaping childbirth experiences (Viirman *et al.*, 2022; Udvari, 2023; Heys *et al.*, 2021; Nguyen *et al.*, 2024; Vuong *et al.*, 2024).

Additionally, socio-demographic factors, including socio-economic status, ethnicity, and education are crucial determinants of maternal outcomes. Women from lower socio-economic backgrounds and vulnerable groups, such as ethnic minorities and teenage mothers, face higher risks of negative maternal and perinatal outcomes, including postpartum depression, preterm birth, and neonatal mortality (Haddrill *et al.*, 2014; Vedeler *et al.*, 2023; Szabó and Veroszta, 2024; Nagy and Lafarge, 2023). The relationship between educational attainment and childbirth satisfaction remains inconclusive in the literature. While some studies suggest that women with higher educational backgrounds report greater satisfaction with their overall experience (Konieczka *et al.*, 2024; Jafari *et al.*, 2017; Dolatian *et al.*, 2008), others argue that highly educated women have higher expectations that are often unmet, leading to lower satisfaction levels compared to women with lower levels of education (Khalife-Ghaderi *et al.*, 2021; Oweis, 2009).

Support (cognitive and emotional) provided by a companion chosen by the woman has been shown to have a positive effect on satisfaction (Srivastava *et al.*, 2015). Fathers' presence

during labour has also been shown to enhance maternal satisfaction, primarily through emotional support and mediation (Hildingsson *et al.*, 2011; Lazzerini *et al.*, 2020). While fathers often report positive experiences, their involvement is sometimes limited by inadequate information or preparation, leading to feelings of uncertainty (Poh *et al.*, 2014). Fathers who were present at birth generally reported a positive experience, although they often felt uncertain about the situation (Dellmann, 2004; Howarth *et al.*, 2019). However, the role of fathers in influencing overall childbirth satisfaction remains understudied. In Hungary, where the healthcare system and social inequalities may uniquely shape maternal experiences, there is limited research on the influence of socio-demographic factors and paternal involvement on childbirth satisfaction.

This study aims to address this knowledge gap by examining general attitudes toward the factors considered essential for obtaining quality obstetric care in Hungary. The study addresses the following questions: What factors affect the Hungarian population's perception of quality obstetric care? How do socio-demographic factors influence satisfaction with childbirth in Hungary? What roles do informal payments play in childbirth satisfaction?

4.1.1. Dual healthcare system and the role of informal payments

Hungary's healthcare system combines state-funded public services and a growing private sector, resulting in a dual practice system that significantly impacts patient satisfaction. Public healthcare is free for individuals insured through social security contributions, which are typically linked to employment. However, the private healthcare system often provides higher quality and faster services, particularly in obstetric care (Veroszta and Szabó, 2021). This "hybridisation" of healthcare has exacerbated social inequalities, as access to better care often depends on financial resources.

A further country-specific and regional (Central and Eastern Europe) factor contributing to healthcare inequalities was the practice of informal payments (IPs), also known as gratitude payments or gratitude money, which originated in the early 1950s. This "specific manifestation of the informal economy found in the healthcare sector" served as a means for patients to pay to healthcare professionals for (or hope to secure) better care and treatment within the public healthcare system (Kornai, 2000). In the Hungarian obstetric care IPs allowed women to have and hire a "chosen/private obstetrician" who would provide care during both prenatal visits and obstetric care during labour, in exchange for these payments. In addition, IPs have been used indirect mechanisms to keep the income of health care professionals consistently low (European Commission, 2017).

The practice of IPs exists in several parts of the world, such as India (Tripathi *et al.*, 2020). However, in the Central and Eastern European region, IPs have distinct socio-historical characteristics. Comparative studies covering Bulgaria, Hungary, and Ukraine (Stepurko *et al.*, 2017; Stepurko *et al.*, 2015), as well as Romania, Bulgaria, and Moldova (Miteniece *et al.*, 2023), have revealed similar mechanisms across countries, with some specific differences. The proportion of healthcare expenditures attributed to IPs varies significantly across the region, accounting for approximately 1.5–4.6% of total health spending in Hungary, 0.3–0.5% in Poland, and around 2% in Bulgaria (Stepurko *et al.*, 2015). Cross-country comparisons indicate that public perceptions of IPs vary significantly: in some countries—especially in Poland but also in Bulgaria—attitudes toward informal payments are less favorable than in others, such as Hungary and Ukraine (Stepurko *et al.*, 2017).

In 2021, the Hungarian government implemented reforms aimed at eliminating IPs and addressing healthcare inequalities. Informal payments were criminalized, and healthcare workers' employment conditions were revised to improve transparency and income parity (European Commission, 2017; Gaal *et al.*, 2021). Similar reform attempts have been made in the region to eradicate corruption in public institutions and increase transparency, including within the healthcare system. For instance, since 1999, Poland's healthcare system has shifted toward providing egalitarian access while also implementing market-type mechanisms (McMenamin and Timonen, 2002). One of the main aims of these early reforms was to eliminate IPs. Other studies have shown that private sector payments have replaced IPs in order to receive more attentive care (Mastylak *et al.*, 2023). Another example: in March 2018, Romania implemented a significant one-time wage raise for public healthcare professionals, which affected the prevalence of informal payments (Mosca *et al.*, 2023). Some of these reforms were not directly aimed at eliminating informal payments but were part of broader anti-corruption policy reform trends (Gadowska, 2010). The Hungarian reforms also included measures to restrict the movement between private and public healthcare systems, meaning that if a patient chooses private care for a medical issue, they must continue to receive care privately for that issue. However, to benefit from public antenatal care, individuals are required to have valid healthcare insurance, while delivery (an acute situation) is supported by the National Health Insurance Fund even without valid health insurance. Despite these efforts, the 2022 Eurobarometer survey revealed that many Hungarians still consider it acceptable to offer gifts or favors to access public services, indicating lingering cultural acceptance of informal practices (European Commission, 2023).

IPs are part of out-of-pocket payments, direct payments “for healthcare goods and services from the household primary income or savings, where the payment is made by the user at the time of the purchase of goods or the use of the services” (Statistics Eurostat). This category also covers spending on pharmaceuticals which means that separating the two dimensions is challenging. Measuring and obtaining data on informal payment expenses remains inconclusive because of its sensitive nature, as people might not report it because of trust and protection issues, similar to corruption (Baji *et al.*, 2017; European Commission, 2022).

4.2. Methods

4.2.1. Study sample and design

The survey was conducted between February and April 2024 on a sample of 1,506 individuals using a cross-sectional design. The research was funded by the MTA TK Lendület Research Group on Reproductive Decisions. The sample was nationally representative by age, gender, and type of settlement. The representativeness of the sample was ensured through post-stratification weighting using the 2022 Census data.

Data collection was carried out by Panelstory. Participants were recruited through a hybrid method: 66.9% (N = 1,008) completed an online questionnaire, while 33.1% (N = 498) participated through in-person interviews, ensuring that individuals without internet access were included. The research focused on reproductive decisions, covering topics such as abortion and its consequences, contraception usage, fertility treatments, and knowledge about adoption. The questionnaire was supplemented with a section focusing on childbirth experiences.

4.2.2. Outcome variable

The questionnaire included seven items that examined who might receive better services. These were the following: those in a better financial situation, those with adequate knowledge about hospital procedures, those who communicate effectively with hospital staff, those who give IPs to hospital staff, those whose relatives are present during childbirth, those who belong to an ethnic or national minority, and those who have a privately hired obstetrician.

The respondents could answer these items on a four-point scale, where 1 meant “not, worse,” 2 meant “no, the same,” 3 meant “yes, better,” and 4 meant “yes, much better.” We

asked everyone these questions, including those who have not had children, as they may still have perceptions or knowledge about obstetric care.

Satisfaction with childbirth was measured with the following item: “How satisfied were you with the obstetric care during the birth of your (youngest) child?” Four response options were provided: very satisfied, rather satisfied, rather dissatisfied, and completely dissatisfied. We deliberately phrased the question in a gender-neutral manner to also capture men’s satisfaction with the childbirth experience.

4.2.3. Independent variables

We included the following independent variables in the analysis: the respondent’s gender (male, female), educational attainment (low, medium, high), financial status (struggles with income, manages on income), the father's presence (present or not in the delivery room during the childbirth), and the year of childbirth (before 1990, between 1990 and 1999, between 2000 and 2009, between 2010 and 2019, or after 2020). The variable respondent's age was excluded from the analysis due to its high correlation with the year of birth of the youngest child. The description of these variables is presented in [Table 2](#).

Table 2. Description of variables included in the survey analysis

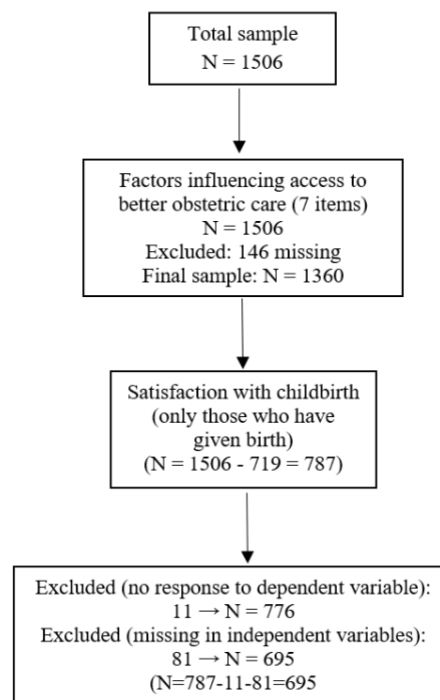
<i>Variables</i>	<i>Values</i>	<i>n</i>	<i>Percentage</i>
Satisfaction	Satisfied	642	89.2
	Not satisfied	78	10.8
Gender	Male	275	38.0
	Female	449	62.0
Education	Low	236	32.6
	Middle	328	45.4
	Higher	159	22.0
Financial status	Struggles	172	23.8
	Does not struggle	550	76.2

Presence of father in the delivery room	Was not present	512	70.7
	Was present	212	29.3
Year of giving birth	After 2020	77	10.6
	2010-2019	187	25.8
	2000-2009	107	14.8
	1990-1999	129	17.8
	Before 1990	224	30.9

4.2.4. Data analysis

We conducted statistical analyses using Stata v18. [Figure 2](#) shows the sample size for the analyses performed. Categorical variables were coded, described by proportions, and comparisons were made using the chi-square test. Factor analysis was employed to construct an index reflecting respondents' perceptions of the factors influencing the quality of obstetric care. Sampling adequacy was assessed using the Kaiser-Meyer-Olkin (KMO) measure, which yielded a value of 0.869, indicating adequate sampling for factor analysis. Bartlett's test of sphericity was also conducted to examine the presence of significant correlations among the variables. A significant Bartlett's test result ($p < 0.05$) indicated the presence of correlations among variables, justifying the use of factor analysis. Following factor analysis, we employed logistic regression to examine associations with birth satisfaction. Although ordinal logistic regression could have been applied to the four-level variable, the highly skewed distribution of the dependent variable—where over 88% of respondents selected one of the two most positive categories—suggested that an ordinal logistic regression would likely encounter estimation issues due to sparse data in the lower categories. To ensure model stability and interpretability, we opted for a binary outcome. Odds ratios and 95% confidence intervals were calculated for each variable. A p-value of <0.05 was considered statistically significant.

Figure 2. Study population of the survey analysis: a study flowchart with the number of included/excluded cases



4.3. Results

4.3.1. Sample characteristics

A total of 1,506 individuals participated in the survey, and the sample was representative of the Hungarian population with 42.3% men and 57.6% women. Consequently, women were slightly over-represented, which may have been influenced by the research topic. The average age of participants was 47.3 years. In terms of educational attainment, 27.2% had primary or vocational education, 47.8% had secondary education, and 25% had a university degree.

Out of the sample of 1,506, 787 individuals had given birth, which means 52% of the sample. However, out of the 787 individuals, 92 did not answer one of the questions we examined, so they were excluded from the sample. Thus, the sample distribution resulted in 61.5% women and 38.5% men. Given that the childlessness rate is higher among men than among women in Hungary (Szalma and Takács, 2018); and women are more likely to respond to questions related to childbirth, they are over-represented in our subsample. The mean ages of male and female participants were 53.8 and 52.9 years, respectively.

As for satisfaction with obstetric care, 1 in 10 respondents reported dissatisfaction. [Table 3](#) shows the distribution of responses according to the gender of the respondents. Satisfaction with childbirth was measured with the following item: “How satisfied were you with the obstetric care during the birth of your (youngest) child?”

Table 3. Satisfaction with obstetric care by gender, survey sample (%)

	<i>Completely dissatisfied</i>	<i>Rather not satisfied</i>	<i>Rather satisfied</i>	<i>Very satisfied</i>
Women	3.2	10.6	39.9	46.4
Men	0	6.1	46.1	47.8

The gender distribution indicates that women report significantly higher dissatisfaction than men: nearly 1 in 7 women (13.8%) reported dissatisfaction, while among men, this rate was approximately half as much (6.1%). The sample includes 32.6% with low education, 45.4% with secondary education, and 22% with a degree. Financially, 76.2% manage comfortably, while 23.8% face difficulties. Less than 30% of fathers were present at childbirth, though this has increased over time, rising from 3.1% before 1990 to 54.6% after 2020.

Given that the study includes respondents whose childbirth experiences occurred in different periods, we also compare satisfaction across birth cohorts.

4.3.2. Factors influencing access to better obstetric care services

In the questionnaire, we examined which resources are considered necessary for better obstetric care across seven dimensions: financial means, knowledge, communication, informal payments, presence of relatives, ethnic background, and having a private (chosen) obstetrician. First, we analysed the full sample to assess perceptions of these factors and then explored whether significant differences emerged based on gender, educational level, and age group (See [Table 4](#)).

Table 4. Factors influencing the quality of obstetric care by gender, age, and educational level, survey sample

Variables	<i>Worse</i>	<i>Same</i>	<i>Some what better</i>	<i>Much better</i>	Gender	Education	Age group
Financial	4.5	27.5	43.3	24.7	0.8	18.0**	25.0***
Knowledge	4.2	40.7	39.2	16.0	0.2	14.0*	17.7**

Communication	3.8	34.4	42.3	19.5	2.8	10.8	13.4*
Gratitude money	5.3	22.1	41.8	30.7	0.5	20.8**	20.4**
Relatives	6.1	39.0	37.4	17.5	1.4	12.2	21.1**
Ethnic background	22.6	47.7	19.8	10.0	5.3	28.3***	21.1**
Private obstetrician	5.4	17.1	38.1	39.3	3.3	21.3**	23.7***

Notes: Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$: Pearson Chi-square (χ^2) test was used to analyse the cross-tabulations, and the significance levels indicated were used to determine the statistical significance of the results.

Nearly 40% of respondents believe that individuals with a private obstetrician receive significantly better care, while an additional 38% think they receive somewhat better care. The fewest respondents (10%) consider ethnic background as a factor influencing the quality of care. Following the provision of private obstetrician services, most respondents (72%) perceive IPs and gratitude money as a factor that leads to better care, followed by those who believe that individuals in better financial situations receive superior care (68%). Similarly, approximately 60% of the sample believes that adequate knowledge of the hospital system and effective communication can lead to somewhat or significantly better care. About 55% of the sample considers the presence of relatives as a factor that contributes to better care.

The last three columns display values from the Pearson Chi-square test, segmented by gender, educational level, and age group. Interestingly, there are no significant differences between genders regarding access to better services for any of the items. However, significant differences based on educational attainment are observed in almost all dimensions, except for the presence of relatives. Individuals with lower educational levels deemed every dimension (excluding the presence of relatives) to be significantly more important compared to those with higher educational levels. Regarding age groups, the 40-59 age group found every dimension to be significantly more important than the other two age groups (18-39 and 60+).

4.3.3. Factor analysis

Based on these seven variables, we attempted to establish a factor structure. The items appeared to separate into two dimensions: financial factors and competency-related factors. However, we had to exclude the ethnicity variable from this structure, as it did not align with either factor. Each entry in [Table 5](#) shows the strength of the association between an individual item and the corresponding underlying factor; these values are referred to as factor loadings. [Table 5](#) also indicates the communality of each variable, which refers to the proportion of variance in each item accounted for by the retained factors.

Table 5. Factor loadings and communality values for attitudinal variables included in sorted, varimax rotated factor matrix, by variable, survey sample (N = 1360)

Item	Financial components (Factor 1)	Competence (Factor 2)	Communality values
Who is in a better financial situation	0.65	n.a.	0.64
Who has adequate knowledge of hospital procedures	n.a.	0.78	0.72
Who communicates effectively with the institution's staff	n.a.	0.75	0.69
Who gives gratuity money to the hospital staff	0.82	n.a.	0.78
Who has a relative present during childbirth.	n.a.	0.63	0.61
Who has a private obstetrician	0.74	n.a.	0.66
Eigenvalue	2.54	1.01	n.a.
Variance explained	42.3%	16.8%	n.a.

Note: n.a. = not applicable.

The first factor, comprising items related to financial components of access to better obstetric care, explained 42.3% of the variance in the included attitudinal items. The second factor, comprising competency-related items, explained a further 16.8% of the variance.

4.3.4. Logistic regression

We examined satisfaction with obstetric care among parents, comparing the opinions of men and women. The estimated factor scores were incorporated into a logistic regression analysis along with selected socio-demographic factors, such as gender, education, subjective financial status, presence of fathers at the birth of the child, and year of delivery.

The logistic regression analysis ([Table 6](#)) revealed a significant association with gender: women reported lower satisfaction with obstetric care compared to men, with an Odds Ratio (OR) of 0.47 (95% CI: 0.267–0.840), indicating that women were less likely to be satisfied with care than men, a difference that was statistically significant ($p < 0.01$). Education was also significantly associated with satisfaction. Individuals with higher educational attainment were less satisfied compared to those with lower education (OR for higher education = 0.40, 95% CI: 0.190–0.830), which suggests that dissatisfaction is more prevalent among those with higher education, potentially reflecting differing expectations or experiences with obstetric care.

Those facing financial struggles reported significantly lower satisfaction with obstetric care (OR = 0.49, 95% CI: 0.276–0.862, $p < 0.01$). This indicates that financial difficulties are associated with significantly lower satisfaction levels with obstetric care.

Table 6. Logistic regression model of satisfaction levels with obstetric care, survey sample (N = 695)

<i>Predictor</i>	<i>Odds ratios</i>	<i>95% CI</i>
Gender (female)	0.47**	0.267-0.840
Education (ref. low)	1	
Middle	0.65	0.334-1.249
Higher	0.40**	0.190-0.830
Financial status (ref. make ends meet)	1	
Struggles financially	0.49**	0.276-0.862
Father's presence	1.69	0.876-3.243
Year of giving birth (ref. before 1990)	1	
After 2020	0.22***	0.094-0.516
2010-2019	1.32	0.542-3.188
2000-2009	0.63	0.270-1.477
1990-1999	0.52	0.246-1.077
Financial components (Factor 1)	0.74*	0.550-0.990
Competence (Factor 2)	1.54**	1.084-2.195

Notes: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, N = 695, Pseudo R = 0.099

The presence of fathers at childbirth was associated with higher odds of satisfaction (OR = 1.69, 95% CI: 0.876–3.243), but this association was not statistically significant.

Those who gave birth after 2020 had substantially lower odds of satisfaction than those who gave birth before 1990 (OR = 0.22, 95% CI: 0.094–0.516, $p < 0.001$).

Higher scores on the financial components factor were associated with lower satisfaction (OR = 0.74, 95% CI: 0.550–0.990, $p < 0.05$), while higher scores on the competence factor were associated with higher satisfaction (OR = 1.54, 95% CI: 1.084–2.195, $p < 0.01$).

4.4. Discussion

Our research examined a relatively underexplored area, satisfaction with childbirth in Hungary. This is particularly significant in light of the 2021 legislative changes that abolished informal payments, along with the option to choose a private obstetrician. Nevertheless, our 2024 survey revealed that the Hungarian population still places significant importance on the financial

dimension, especially the choice of private obstetricians and the phenomenon of informal payments. We did not find significant gender differences, but in terms of educational attainment, respondents with lower levels of education and those in the 40-59 age group tend to believe that access to better care is facilitated by informal payments and private obstetrician consultations. Individuals with lower educational levels also believe that those belonging to an ethnic or national minority receive better obstetric care. This is surprising, as previous research has shown that members of ethnic minorities, particularly Roma women, may experience poorer and discriminatory care (Szabó and Veroszta, 2024). Our factor analysis revealed two dimensions based on the six variables: a financial dimension and a competency dimension.

When we examined a narrower sample – those who had childbirth experience, either directly or as fathers whose children were born – we found that 1 in 10 respondents expressed dissatisfaction with obstetric care, which is roughly consistent with the general 8-10% rate of negative childbirth feedback (Baas *et al.*, 2017; Viirman *et al.*, 2022; Veroszta *et al.*, 2022; Vedeler *et al.*, 2023). However, if we consider that other studies have focused only on women, the dissatisfaction rate in our study is higher, with 1 in 7 women reporting dissatisfaction.

The results of the logistic regression analysis also highlight that women are more dissatisfied with childbirth than men. This is surprising, because some research shows that men had similar experiences as their partners (Howarth *et al.*, 2019). Further research is needed to explore gender differences in satisfaction with obstetric care. Furthermore, the higher someone's level of education, the more likely they are to be dissatisfied, and those who consider the financial components more important are also more dissatisfied. Previous research has highlighted the importance of educational attainment, with some studies reporting effects consistent with our findings (Khalife-Ghaderi *et al.*, 2021; Oweis, 2009). However, our results contradict those of Konieczka and colleagues (2024), who observed that female respondents with higher levels of education exhibited significantly higher childbirth satisfaction—particularly regarding the alignment of expectations with the birth plan. This positive association between maternal education and childbirth satisfaction was further supported by research from Jafari *et al.* (2017) and Dolatian *et al.* (2008), which demonstrated that childbirth satisfaction increased with higher levels of mothers' education. Thus, there are contradictory findings in the literature regarding the role of educational attainment.

In the Hungarian case, the lower level of satisfaction observed among highly educated women may be explained by the fact that they are generally more familiar with healthcare processes, more aware of their rights and options, and enter the healthcare system with specific expectations (e.g., after attending childbirth preparation classes). However, the Hungarian

healthcare system may not be equipped to meet these expectations. In contrast, less informed or lower-educated patients tend to have less clearly defined expectations, making them less likely to experience disappointment and more inclined to perceive their experiences as normal.

Our examination of both recent and earlier childbirth experiences revealed that those who gave birth after 2020 were less satisfied with obstetric care compared to those who gave birth before 1990. It is noteworthy that those who gave birth after 2020 were the least satisfied. One possible explanation concerns the removal of informal payments and the associated reorganisation of obstetric care. However, the lower satisfaction observed after 2020 may also be related to the COVID-19 pandemic and the state of emergency declared in the spring of 2020. Numerous studies have investigated the impact of the pandemic on childbirth satisfaction, with many findings indicating that COVID-19 increased dissatisfaction in most settings, primarily due to unpredictability and heightened stress (Preis *et al.*, 2022; Janevic *et al.*, 2021; Marino-Narvaez *et al.*, 2021; Bejer *et al.*, 2023). This, in turn, had a significant negative impact on maternal well-being, notably contributing to a rise in postpartum depression. However, some research—such as studies conducted in Italy (Inversetti *et al.*, 2021) and Russia (Suarez and Yakopuva, 2022)—has found no differences in overall satisfaction between pre-COVID-19 and during COVID-19 birthing cohorts.

Therefore, it is difficult to distinguish whether the lower satisfaction observed after 2020 is associated with the abolition of IPs, COVID-19-related restrictions, or other contemporaneous changes in obstetric care. During the COVID-19 pandemic, Romania (22%) and Bulgaria (19%) recorded the highest incidence of bribery in the public health sector among all EU member countries (Drugă, 2022). In the Romanian context, Mosca *et al.* (2023) found that patient-reported informal payments decreased during the 'low payment' period (before the 2018 wage increase for healthcare workers) and further declined during the 'high payment' period (after the 2018 wage increase). Additionally, the share of respondents willing to report informal payments increased during the “high pay” period, suggesting a greater willingness to express dissatisfaction with health services and IPs, though this trend slowed during the first lockdown in 2020. Contrarily, some argue that the pandemic may have acted as a catalyst for IPs (Drugă, 2022). Thus, in the Hungarian context, the literature suggests – and further investigation is warranted – to assess the extent to which underlying dissatisfaction during COVID has been compounded by restrictions on informal payments, given that demand for such payments may have increased (for quicker services, for example), but legislative regulations prevented their emergence due to concerns over legal consequences. However,

other studies have highlighted the role of marketisation, that private sector payments have replaced IPs in order to receive more attentive care (Mastylak *et al.*, 2023).

The state of emergency affected hospital visits as well, although the father could be present during childbirth even during the COVID-19 pandemic. At the same time, a positive trend can be observed in fathers' attendance at childbirth: over the last decade and a half, their presence has increased, and since 2010 more than half of fathers have been present at births. Although the association between paternal presence and childbirth satisfaction was positive, it was not statistically significant. Future studies with larger samples could provide more robust evidence on this association.

4.4.1. Strengths and limitations

One of the key strengths of this study is that it draws on a nationally representative survey, allowing population-level analysis of perceptions of obstetric care. Additionally, the inclusion of respondents whose childbirth experiences occurred in different periods enabled comparisons across birth cohorts, providing insight into temporal differences in satisfaction with obstetric care. However, the cross-sectional and retrospective design does not allow these differences to be attributed causally to recent legislative changes.

A significant limitation of the study is the small sample size when focusing on individuals who gave birth in recent years. This limited sample size affects our ability to examine the influence of factors such as paternal presence on satisfaction with obstetric care with sufficient statistical power. Additionally, having data from both partners would allow for a more comprehensive analysis. Measuring satisfaction levels for both women and men regarding the same childbirth experience would provide a more nuanced understanding of the dynamics of obstetric care satisfaction. Moreover, we did not assess the effect of the mode of delivery, which previous research suggests might be an important factor in analysing birth experience (Guittie *et al.*, 2014; Döblin *et al.*, 2023; Viirman *et al.*, 2023; Spaich *et al.*, 2013).

4.5. Conclusions

Our results suggest that financial considerations, including informal payments and private obstetricians, remain salient in public perceptions of obstetric care despite the legislative changes. Awareness-raising campaigns are necessary to clarify that financial status should not influence obstetric care, especially since lower-educated individuals and those aged 40-59 perceive a strong link between financial means and care quality. Moreover, those who prioritize competency report higher satisfaction, highlighting the need for effective communication and

professional knowledge in obstetric care. Notably, individuals who gave birth after the 2020 legislative change were significantly less satisfied with their care. Further research is needed to understand this trend, particularly given its overlap with the COVID-19 pandemic. Our findings emphasize persistent inequalities in access to obstetric care, underscoring the need for targeted awareness campaigns on the elimination of informal payments.

4.6. Declarations

4.6.1. Ethics approval and consent to participate

This study was conducted in accordance with the appropriate national guidelines applicable in Hungary. Ethical approval was granted by the HUN-REN Centre for Social Sciences Institutional Ethics Review Board on August 15, 2024, under reference number 1-FOIG/18-26/2024. Informed consent was obtained from all participants prior to their participation in the survey. By completing the survey, participants provided explicit consent to participate in the study. The study adhered to the Declaration of Helsinki.

4.6.2. Consent for publication

Not applicable.

4.6.3. Availability of data and materials

The survey was specifically designed and developed by the authors for the purposes of this research. The English version of the questionnaire is provided as a supplementary file (Appendix). The datasets used and/or analysed during the current study are available from the corresponding author upon reasonable request.

4.6.4. Competing interests

The authors declare no competing interests.

4.6.5. Funding

The study was supported by the Momentum Programme of the Hungarian Academy of Sciences under Grant LENDULET_2021-78.

4.6.6. Authors' contributions

OU wrote the literature review, conducted the literature selection, and drafted the main manuscript, under the supervision of ISZ. ISZ prepared the main tables, conducted the logistic regression analysis, and guided the overall analysis process. Both authors contributed

collaboratively to the interpretation of the results. All authors reviewed and approved the manuscript.

4.6.7. Acknowledgements

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5. MAKING DO, UNEQUALLY: REPRODUCTIVE GOVERNANCE, BRICOLAGE AND RACIALISED ACCESS TO CHILDBIRTH CARE IN HUNGARY¹⁴

Abstract

This chapter examines how women navigate childbirth care in Hungary's hybrid healthcare system after the 2021 reform that reconfigured care pathways. Drawing on 26 semi-structured interviews with Roma and non-Roma mothers from diverse social backgrounds, it uses healthcare bricolage as a lens for analysing obstetric care. The findings show that women assembled public, private, informational and relational resources to secure predictability, continuity and respectful treatment. Bricolage was not primarily an expression of consumer choice, but a form of anticipatory risk management and a way of gaining a sense of control in response to institutional fragmentation and expected mistreatment. Three literature-informed forms are identified: added-to-system bricolage, through private antenatal care, chosen doctors and paid preparation; within-system bricolage, through public preparation, self-research, companions and dignity-preserving strategies; and alternative bricolage, through private or home birth pathways. These forms were socially stratified; money could purchase information, comfort and partial continuity, but did not protect Roma women from racialised discrimination. The chapter contributes to the sociological study of healthcare by expanding healthcare bricolage as structurally produced patient work in formally universal but increasingly fragmented systems. Reading these practices through the lens of reproductive governance, it argues that bricolage is not only a response to institutional fragmentation but one of the everyday, socially stratified forms through which reproductive governance is enacted.

Keywords: childbirth, reproductive governance, healthcare bricolage, racialisation, informal payments

¹⁴ This chapter is an extended version, prepared by the author, of a co-authored manuscript, "Does money really talk? Bricolage in the context of racialised and classed access to childbirth care in Hungary," written with Ivett Szalma and Judit Durst and submitted to *Sociology of Health & Illness* on 19 June 2026 (under review).

5.1. Introduction

Childbirth is both a major life and a social event, and a growing body of research highlights the importance of a positive birth experience (Baas *et al.*, 2017; WHO, 2018). Women increasingly expect not only safe medical outcomes but also a supportive atmosphere, clear communication, continuity of care and a sense of control during childbirth (Fisher *et al.*, 2019). The absence of these elements is associated with negative experiences, including loss of control, distress, complications related to medical interventions, and longer-term consequences for well-being and future childbearing intentions (Gottvall and Waldenström, 2002; Niebler *et al.*, 2016; Rados *et al.*, 2021; Viirman *et al.*, 2022; Heys *et al.*, 2021). However, access to such experiences is unevenly distributed according to social hierarchies (Vedeler *et al.*, 2023; Zadoroznyj, 1999). In hybrid healthcare systems, some healthcare users can rely on private care that offers predictability and personalised attention, while others depend on public services that may be perceived as fragmented, overstretched, or unresponsive (Bradby *et al.*, 2020; Liamputtong, 2005).

In settings where public provision is perceived as uncertain or insufficient, and fully private care remains financially out of reach for many, women often combine different forms of care. These combinations may include mixing private antenatal services with public hospital births, relying on informal knowledge and networks, mobilising additional support during labour, or, in some cases, seeking alternatives outside public provision. This chapter conceptualises such practices through the lens of healthcare bricolage (Phillimore *et al.*, 2015; 2018; 2019a).

These practices do not unfold on neutral ground, however. Childbirth takes place within a field structured by reproductive governance, that is, the mechanisms through which states, institutions, and medical authority produce, monitor, and morally evaluate reproductive behaviour (Morgan and Roberts, 2012). In Hungary, demographic anxieties, selective pronatalist policy, and strong medical hierarchies shape not only the organisation of obstetric care, but also the moral classifications through which women are judged. Healthcare bricolage could be interpreted as the situated, everyday counterpart to this governing arrangement: it is the work through which women navigate, negotiate, and occasionally circumvent the conditions that reproductive governance sets. Intersectionality, in turn, explains why the need for this work, and the capacity to carry it out effectively, is unevenly distributed. Reading the three together – reproductive governance, healthcare bricolage, and intersectionality – makes it possible to move from what governs childbirth care to how it is lived and unequally managed.

Existing research has primarily examined healthcare bricolage in contexts of superdiversity and complex population diversity, where mainstream healthcare services are often poorly aligned with heterogeneous needs (Phillimore *et al.*, 2015; 2018; 2019a; Bradby *et al.*, 2020). This chapter extends this literature by examining a formally universal obstetric system in which bricolage is not limited to groups positioned as outsiders to healthcare provision.

This chapter examines how women navigate obstetric care in Hungary under conditions of institutional uncertainty, particularly in the aftermath of the 2021 reform that criminalised informal payments and reconfigured the relationship between public and private care. The Hungarian case is particularly relevant because childbirth care operates within a hybrid post-socialist healthcare system historically shaped by informal payments, strong medical hierarchies, and increasing fragmentation between public and private provision. The key question is therefore how women navigate and assemble obstetric care under conditions of institutional uncertainty, and how access to predictable and respectful care becomes unevenly distributed across different social positions.

Drawing on 26 semi-structured in-depth interviews with mothers from different social backgrounds, the chapter explores how participants combine public and private services, informal knowledge, and social support to create a sense of continuity, control and respectful care around childbirth. I argue that these practices are not simply about expanding options. Rather, they are about making care workable in a context where institutional arrangements are often experienced as uncertain, even by women who are not positioned as marginalised healthcare users.

The chapter contributes to scholarship on health inequalities and healthcare bricolage in three ways. First, it extends healthcare bricolage scholarship by applying the concept to obstetric care through the lens of reproductive governance, showing that bricolage is not only a strategy used by groups whose needs are poorly recognised by mainstream services, but it is a widespread mode of navigating care within formally universal but fragmented healthcare systems. Second, it examines how women construct care pathways within the post-2021 institutional context, in which previous mechanisms for securing predictability and continuity have been reconfigured, making visible how reproductive governance operates not only through policy and institutions but through the everyday work these arrangements impose on women. Third, it highlights how these practices are unevenly available, reflecting broader socio-economic inequalities and processes of racialisation.

5.2. Theoretical framework

5.2.1. Healthcare bricolage

The concept of bricolage originates in Lévi-Strauss's anthropological work (1966) and has been adapted to different fields of research (e.g., social policy, business, management, entrepreneurship, design) to describe how individuals navigate complex and constrained environments (Mateus and Sarkar, 2024). Building on this tradition, the UPWEB project developed the broader concept of welfare bricolage and subsequently applied and refined it in relation to healthcare, examining how individuals assemble and combine formal, informal, private, and relational resources to meet health-related needs (Phillimore *et al.*, 2015; 2018; 2019a). Bricolage is often conceptualised as a form of adaptive agency, highlighting individuals' capacity to creatively "make do" by combining available resources (Phillimore *et al.*, 2019b). However, less attention has been paid to contexts in which bricolage becomes necessary within mainstream healthcare systems themselves, including for users whom these systems are formally designed to serve.

In this paper, bricolage is not approached primarily as a sign of resilience or individual creativity, but as a diagnostic lens through which structural deficiencies and institutional fragmentation in Hungarian obstetric care become visible. Rather than foregrounding the agency of the bricoleur (Phillimore *et al.*, 2019b), the analysis emphasizes the determinants and unequal distribution of the capacity for agency, the differing social positions of women who engage in bricolage, and the patterned typologies of their "making do".

In the Hungarian case, bricolage is interpreted primarily as a response to institutional uncertainty, fragmentation, and the reconfiguration of previously available mechanisms of predictability. Thus, bricolage is interpreted here primarily as a response to policy-induced uncertainty and as a system-immanent, structurally induced mechanism rather than a freely chosen strategy.

However, there are pitfalls and dangers in interpreting bricolage exclusively in these terms, particularly in contemporary neoliberal policy discourses, a reading that does not derive from the concept's original anthropological formulation but from its possible reinterpretation within contemporary frameworks, namely as a strategy of self-empowerment, as an embodiment of agency and resilience. In extreme cases, such an interpretation risks legitimizing the withdrawal of welfare provision. This risk is particularly relevant in the Hungarian obstetric context, where the expansion of private services and the retreat of the public sector can easily reframe bricolage as responsible self-management.

This chapter builds on the existing literature by approaching bricolage as a practice shaped by institutional constraint and unequally distributed resources. It places these practices within the social hierarchies and institutional conditions that make them necessary and unequally available.

Following the five-category typology developed by Phillimore *et al.* (2019b), this study uses different forms of bricolage as sensitising concepts “that inform research but do not determine the scope of perceivable findings” (Timmermans and Tavory, 2012, p. 173) to organise the empirical material. In brief, the typology moves from relying exclusively on publicly funded care without additional support (“no bricolage”), through combining public care with informal knowledge and support (“within-system bricolage”), to supplementing public provision with services outside the public system (“added-to-system bricolage”), and finally to pathways that bypass the public system altogether (“alternative”). Phillimore *et al.*'s fifth category, “no resources used”, is analytically inapplicable to childbirth in the Hungarian context, since birth is an unavoidably institutional event that no participant could undergo without drawing on some resources at all. The “no bricolage” category was excluded on different grounds: not because it is conceptually impossible, but because it did not occur in the material, a point developed in the analysis below, where the absence of any woman relying on standard public provision alone is treated as a finding in its own right. In the refined typology applied here, the analysis therefore works with the remaining three categories. Rather than applying these categories as a fixed typology, the analysis adapts them to the specific context of childbirth, where bricolage often takes anticipatory forms oriented towards securing predictability and respectful treatment. Understood this way, bricolage becomes the level at which reproductive governance can be observed empirically: not as abstract policy, but as the concrete, unequally distributed work of making care workable.

5.2.2. Inequality, stratification, and racialisation in childbirth care

The structurally grounded understanding of bricolage resonates with broader sociological literature on healthcare inequalities. Access to care is not determined only by formal entitlements, but also by patients' social position and their capacity to navigate institutional complexity, mobilise resources, and manage uncertainty. Previous research shows that the forms and outcomes of bricolage are shaped by socio-demographic and socio-economic factors such as education, income, gender, migration background, and trust in healthcare providers (Phillimore *et al.*, 2015; 2018; 2019b). These factors influence not only which resources people

can access, but also how effectively these resources can be converted into safer, more trustworthy, or more efficient care.

Healthcare inequalities are also structured through processes of racialisation, understood as the symbolic and historical process of “naturalising” difference, whereby history and culture are transformed into “dissimilarities of essence” or biology (Wacquant, 2022). Research has documented how racialised and marginalised groups are more likely to experience lower-quality care, reduced autonomy, discriminatory treatment, and diminished credibility within healthcare systems (Kóczé, 2020; Wacquant, 2022). In childbirth care, these inequalities are particularly consequential, because women’s accounts of pain, fear, risk, and bodily autonomy are interpreted within institutional hierarchies and moral assumptions about deservingness, responsibility, and “proper” motherhood (Castro and Savage, 2019). Racialisation therefore shapes not only access to care, but also how women are seen, heard, believed, and treated within care encounters.

In this context, bricolage can be understood as a stratified practice. While many women may engage in some form of resource combination, the available forms and their effectiveness are unevenly distributed. Money, knowledge, social networks, geographical location, and racialised credibility shape both the need for bricolage and the capacity to mobilise it successfully. Bricolage is therefore not simply an individual response to complexity, but a socially situated practice through which broader inequalities are reproduced, negotiated, and sometimes partially mitigated.

5.2.3. Childbirth as a site of healthcare bricolage

Applying healthcare bricolage to childbirth also requires conceptual extension. Unlike many forms of healthcare use centred on illness, childbirth is a socially embedded life event that takes place within institutional settings characterised by medical authority, uncertainty, and asymmetrical power relations. Although women often prepare extensively for birth in advance, childbirth remains difficult to fully control, as decisions may ultimately be shaped by institutional routines, professional authority, and the contingencies of labour. In contexts where predictable and supportive care arrangements are lacking, women may begin to construct care pathways before birth takes place, drawing on public and private services, informal knowledge, and relational support.

Bricolage thus provides a useful analytical lens for understanding how women assemble workable trajectories within institutional environments that do not offer stable, coordinated, or sufficient support. In the case of childbirth, bricolage often takes an anticipatory form, oriented

towards minimising uncertainty, avoiding negative experiences, and securing a sense of safety and control. At the same time, the possibility of constructing such trajectories is unevenly distributed.

5.3. Hungarian background

The Hungarian healthcare system is formally based on universal coverage, with access to publicly funded services primarily linked to social insurance (Udvari and Szalma, 2025). Obstetric and antenatal care are provided without direct charge through a system involving obstetricians, midwives, general practitioners and health visitors (Veroszta and Szabó, 2021). In practice, however, the rapid expansion of private healthcare has produced an increasingly hybrid system, in which patients often combine public and private services to secure more timely, predictable and personalised care.

This hybridity has contributed to unequal access to continuity and responsiveness in care. Although public care remains formally universal, financial resources shape women's ability to access faster consultations, private antenatal care, chosen professionals and more individualised attention (Veroszta and Szabó, 2021). A prominent feature of this system was the practice of informal payments, also known as gratitude payments, through which patients sought to secure better treatment and more predictable relationships with healthcare providers (Udvari and Szalma, 2025). In obstetric care, this often meant choosing a specific obstetrician who provided antenatal care and was expected to be present at birth. While this arrangement reproduced inequalities, it also functioned as an informal coordination mechanism, offering some women continuity and trust within an otherwise fragmented system (Baji *et al.*, 2017).

A major turning point occurred on 1 January 2021, when the Hungarian government brought into force the criminalisation of informal payments, meaning that both giving and accepting informal payments were made illegal, punishable by up to one year in prison, except for small-value gifts under Act C of 2020 on the Employment Status of Health Workers, adopted by the National Assembly on 6 October 2020 (Szabó and Veroszta, 2021; Gaal *et al.*, 2021). The reform was driven by long-standing issues, including a human resource crisis, the entanglement of public and private sectors (dual practice), and the persistence of informal payments. Understood in the terms of this chapter, the 2021 reform is not merely a technical or anti-corruption measure but itself an instance of reproductive governance: through it, the state reconfigured the conditions under which women access obstetric care and redefined the boundary between legitimate and illegitimate ways of securing continuity and trust.

The reform therefore altered not only payment practices but also the organisation of continuity in obstetric care. Although it aimed to reduce corruption and inequality, it removed a mechanism through which some women had secured the presence of a known obstetrician at birth, increasing uncertainty about who would attend them and how care would be organised. This earlier arrangement was itself unequal and did not guarantee respectful or less interventionist care: women with chosen providers had higher rates of obstetric intervention, and although they reported greater autonomy, 42% still experienced some form of disrespectful care, including procedures performed without informed consent (Baji *et al.*, 2017).

Beyond the unpredictability of professional presence and continuous support, approaches within public obstetric care differ greatly across hospitals, as there is no unified obstetric philosophy or protocol; a characteristic that was already present before 2021 but became more visible in the absence of informal continuity mechanisms. Although international guidelines exist, are available, and have been encouraged to be implemented, they are not applied at a systemic level in Hungary; “Families cannot rely on a national protocol that uniformly follows up-to-date international evidence-based recommendations and that is consistently observed by providers; instead, local protocols and the mindset of the doctor and midwife present at the birth determine what kind of care the woman receives” (Kisdi, 2016, p. 94). This also means that even within a single department, substantial differences can be found in attitudes and everyday practices.

Inequalities in Hungarian obstetric care are not only socio-economic but also shaped by processes of racialisation. Roma people, the largest ethnic minority group in Hungary, face longstanding structural disadvantages and discrimination across multiple domains, including healthcare (Kóczé, 2020; Wacquant, 2022). Research shows that Roma women are more likely to rely exclusively on publicly funded care, have more limited access to higher-quality services, and report less favourable treatment during childbirth (Balogh, 2025; Bodrogi, 2016; Balogh and Geller, 2019; Király *et al.*, 2021; Szabó and Veroszta, 2024). Qualitative studies further document fear, lack of information, discriminatory treatment and obstetric violence in Roma women’s childbirth narratives (Balogh-Szabó, 2023).

The Hungarian obstetric system is therefore characterised by formal universalism, institutional fragmentation and socially stratified access to care. The disruption of informal coordination mechanisms post-2021 alongside the expansion of private services, has increased the importance of individually mobilised strategies for securing predictability, trust and respectful treatment (Kisdi and Földházi, 2024). It is within this context that healthcare bricolage becomes particularly relevant.

5.4. Data and method

5.4.1. Research design, sampling and interviews

The study adopts an exploratory qualitative design based on semi-structured in-depth interviews. The research focuses on how women construct and navigate care pathways within a hybrid healthcare system, with particular attention to how these practices are shaped by institutional uncertainty.

The sample includes women from diverse social backgrounds who gave birth in primarily public and, in some cases, private obstetric settings. This variation reflects the hybrid organisation of obstetric care in Hungary and allows the analysis to examine how women combine different forms of care in practice. The aim was to capture a range of care trajectories across social positions, including differences in education, place of residence, ethnicity, and parity.

Participants were reached through several channels, including NGOs working in the field, research calls posted in online groups, and networks of the researcher. The most reliable and successful channels proved to be personal networks and professionals, which were further expanded through snowball sampling that eventually became the main recruitment strategy. One possible explanation for the difficulties in reaching mothers through online calls is that the interview topic is highly sensitive and demanding, both emotionally and in terms of time; consequently, participation required a high level of trust. Without personal acquaintances, approaching women to participate was challenging. In overcoming this issue, bridge persons played a crucial role in facilitating access to participants and encouraging openness.

The final sample consists of 26 interviews. Interviews were conducted between 2022 and early 2026, with the majority taking place in 2024. Most interviews were carried out face-to-face ($n = 18$), while others were conducted online ($n = 8$), depending on participants' availability and preferences. 13 interviews out of the total were conducted during field visits in a region of Northern Hungary, in participants' everyday environments, allowing for greater contextual embeddedness of the data. Interviews were conducted in Hungarian and followed a narrative approach centred on childbirth experiences, while also covering broader life contexts, including family background, social networks, reproductive decision-making and experiences of navigating public and private care. In some cases, interviews took place in socially dense domestic settings where other family members were present; others occasionally listened, joined the conversation, asked follow-up questions ("tell her more about that, when..."), or added their own similar experiences, most often in interviews conducted in two North-

Hungarian localities. Although these situations occasionally produced multi-voiced interactions, the presence of trusted others often facilitated the interview process given the sensitivity of the topic. Nevertheless, the primary unit of analysis remained the individual interview.

All participants provided informed consent prior to the interviews and were assured of anonymity and the voluntary nature of participation. Given the sensitivity of the topic, special attention was paid to the emotional and physical protection of participants and to minimising potential harm, including the risk of re-traumatisation; participants could skip any question or stop at any time, and were informed about available professional support networks. [Ethical approval](#) for the research was granted by the Research Ethics Committee of Corvinus University of Budapest (KRH/111/2024).

5.4.2. Positionality

Qualitative interviews are shaped by asymmetrical power relations, while the knowledge they produce is also influenced by the researcher's social location (Finch, 1984; Kvale, 2006; Soedirgo and Glas, 2020). Reflexive attention to my own position and that of the participants therefore guided the processes of data collection, analysis, and interpretation.

As a non-Roma, middle-class researcher without personal experience of childbirth, my position did not appear to create overt barriers during the interviews. In several cases, my lack of personal experience positioned me as a learner, as mothers explained technical and experiential aspects of childbirth and temporarily assumed the position of experts within the interview relationship. Within Roma communities, bridge people and prior connections played an important role in establishing access and trust. Spending time in participants' homes and communities, together with flexibility during recruitment and interviewing, further supported rapport.

Given the sensitivity of the topic, I aimed to create an empathetic setting in which participants could recount difficult or traumatic experiences without fear of judgement or misunderstanding. Participants did not receive financial incentives, and reciprocity therefore remained largely limited to shared time and attentive listening. This could not remove the structural asymmetry concerning who benefits materially and symbolically from the research (Kvale, 2006). Several women nevertheless stated that telling their stories had been meaningful and that they considered the topic important and insufficiently discussed in public discourse (Colbourne and Sque, 2005; Birch and Miller, 2010). Such responses suggest that the interview

itself could have value for some participants, but they should not be understood as resolving the broader inequalities inherent in academic knowledge production.

5.4.3. Sample characteristics

The final sample includes 26 women aged between 22 and 44 from diverse social backgrounds (see [Table 7](#) for detailed participant characteristics). Participants were recruited from four main types of locations: the capital (n = 7), its agglomeration (n = 7), other cities (n = 7), and a disadvantaged village in Northern Hungary (n = 5). The sample was intentionally constructed to include both Roma (n = 13) and non-Roma (n = 13) participants in order to examine how ethnicity and racialised inequalities shape experiences of obstetric care.

Table 7. Participants' characteristics, interview study (N = 26)

Pseudonym	Year of Birth	Occupation	Education	Place of Residence	Ethnicity*	Birth Years	Bricolage**
<i>Abigail</i>	1993	AI expert	H	Agglomeration	NR	2020 (twins), 2024	1
<i>Tina</i>	1990	Pathologist	H	Capital	NR	2022	2
<i>Gina</i>	1988	Anaesthesiologist	H	Capital	NR	2023	1
<i>Maria</i>	1992	PhD student	H	Capital	R	2023	3
<i>Dina</i>	1993	University student	H	Agglomeration	NR	2018, 2020	1; 3
<i>Mona</i>	1996	Shop assistant	L	City	R	2020, 2023	1
<i>Kira</i>	1981	Homemaker	L	City	R	2005, 2009, 2010, 2021	2
<i>Kathy</i>	2002	Homemaker	L	City	R	2020, 2023	2
<i>Lina</i>	2002	Nail technician	L	City	R	2023	1
<i>Nancy</i>	1994	Coach, salesperson	H	Capital	NR	2020, 2022	1
<i>Dora</i>	1991	Office worker	H	Agglomeration	NR	2021	2
<i>Zoe</i>	1992	Curator	H	Agglomeration	NR	2023	1
<i>Britney</i>	1994	Soldier	H	Capital	NR	2023	1
<i>Susy</i>	1994	HR consultant	H	Capital	NR	2023	1
<i>Kloe</i>	1992	Homemaker	L	Village	R	2011, 2013, 2023	2
<i>Carmen</i>	2000	Homemaker	L	City	R	2017, 2024	2
<i>Nara</i>	1993	Homemaker	L	Village	R	2013, 2016, 2021	2
<i>Kendall</i>	1980	Homemaker	L	Village	R	1995, 1997, 1999, 2001, 2008, 2010, 2012	2
<i>Hope</i>	1995	Homemaker	L	Village	R	2012, 2014, 2016, 2020, 2022	2
<i>Lily</i>	1999	Homemaker	L	Village	R	2015, 2019, 2022	2
<i>Brenda</i>	2001	Doula	H	Agglomeration	NR	2021	1
<i>Alice</i>	1995	Print production inspector	L	Agglomeration	NR	2024	2
<i>Renata</i>	1994	Freelance journalist	H	City	R	2021	2
<i>Romi</i>	1999	Homemaker	L	City	R	2016, 2018, 2021	2
<i>Sophie</i>	1994	Health visitor	H	Capital	NR	2025	1
<i>Lotte</i>	1991	Sport coach, office assistant	L	Agglomeration	NR	2024	2

*NR = non-Roma; R = Roma (self-identified).

**1: Added-to-system; 2: Within-the-system; 3: Alternative. If only one is listed, it refers to all births.

Educational background was categorised into two groups based on the completion of upper secondary education. The sample includes both higher-educated (n = 13) and lower-educated women (n = 13). Half of the participants (n = 13) had more than one child, enabling within-case comparisons across multiple birth experiences. While the analysis focuses primarily on births after the 2021 reform, two earlier birth experiences were included because

they provided important insight into continuity and change in care-seeking practices across the reform period.

5.4.4. Analytical approach

The analysis follows an abductive approach (Thompson, 2022; Timmermans and Tavory, 2012), moving iteratively between the empirical material and theoretical concepts. Phillimore *et al.*'s healthcare bricolage typology (2019b) was used as an interpretative framework rather than as a fixed coding scheme. In the first stage of analysis, the three categories that proved relevant to the Hungarian obstetric care context – added-to-system, within-system, and alternative bricolage – served as initial top-level codes. Coding proceeded iteratively, involving multiple rounds of revisiting transcripts, refining categories, and examining overlaps between forms of bricolage. This process allowed for the identification of patterned care-seeking strategies, while also maintaining attention to the unequal conditions under which these strategies became possible. Interview transcripts were coded using MAXQDA qualitative data analysis software. The excerpts included in this chapter were translated into English by the author.

Additional themes identified during the coding process included the broader role of socialisation, patient–professional hierarchies, social prestige, the financialisation of institutions, the role of ethnicity, informal and formal reproductive knowledge, different forms of support, social networks, a sense of control, luck, trust, communication, feelings of guilt, breastfeeding, and COVID.

5.4.5. Limitations

The heterogeneous composition of the sample makes it possible to explore variation in care trajectories across differences in social status, ethnicity, place of residence and access to private care. At the same time, this heterogeneity limits strict comparability between cases, as participants differed not only in social background but also in parity, birth history and local care settings.

The use of snowball sampling may have introduced network-based biases, although to mitigate this bias I rolled different snowballs. Interview settings also varied. Some interviews were conducted online, while others took place in participants' everyday environments, including socially dense domestic settings where family members were sometimes present. These settings enriched the data by situating birth narratives within everyday social relations, but they also reduced methodological uniformity.

The data collection period extended from 2022 to early 2026, although most interviews were conducted in 2024. This means the material captures experiences from different moments after the 2021 reform but does not allow for a systematic longitudinal analysis of change over time.

I did not ask directly about informal or paid amounts, or about specific sums. This was a conscious decision, as reported amounts are difficult to compare across participants and contexts. Where financial information emerged spontaneously, I incorporated it into the analysis, based on participants' own accounts. However, this does not allow systematic comparison with other household expenditures. At the same time, participants' material circumstances inevitably shape what counts as a "burdensome" cost versus an insignificant expense.

Finally, my own position was reflected upon during data collection, interpretation and writing, particularly in relation to differences in social position, ethnicity and institutional power. This reflexive attention was important for reducing extractive dynamics and avoiding the reproduction of hierarchies within the research process (Kvale 2006; Soedirgo and Glas 2020).

5.5. Findings

The analysis proceeds in three steps: it first examines the motivations that made bricolage necessary, then presents the main forms through which women assembled care, and finally analyses how access to these forms was stratified across social positions.

5.5.1. Bricolage as anticipatory risk management

Women's bricolage practices were primarily driven by the pursuit of a "good" birth in a context where negative experiences were widely anticipated. Rather than relying on institutional routines, women felt they had to actively construct safety, predictability, and respectful care. In this sense, bricolage appeared as a predominantly defensive and anticipatory strategy: a "good" birth had to be actively secured rather than taken for granted. This necessity was near-universal in the sample: not a single participant navigated childbirth by relying on standard public provision alone, without recourse to additional knowledge, relationships, services, or preparation. That the "no bricolage" scenario did not appear at all is itself an indication that, in this context, bricolage functions less as an optional strategy than as a practical necessity. Women's motivations converged around four interrelated dimensions: fragmented and often contradictory sources of knowledge, institutional unpredictability, anticipated or experienced mistreatment, and fear of pain.

A key starting point was the experience of informational overload combined with a lack of clear, reliable guidance. Women were exposed to multiple, often contradictory sources, both formal and informal, without a stable point of reference within the healthcare system. As Abigail, a thirty-year-old non-Roma AI developer, mother of twins and one son from the agglomeration area, described: “each of them, the paediatrician, the health visitor, the midwife, said different things.” In this context, uncertainty extended beyond conflicting information to include the unpredictability of who would be present during childbirth and whether any familiar, trusted professional would be available at all. Following the 2021 reform and the reconfiguration of the chosen obstetrician model, continuity could no longer be assumed as a stable feature of care. Predictability therefore had to be actively reconstructed through other resources, relationships, and forms of preparation.

Time and accessibility also emerged as motivations for bricolage. Women highlighted the difficulty of navigating an overburdened public healthcare system, where long waiting times and limited opportunities for consultation made continuous and responsive care difficult to access. As Sophie, a thirty-two-year-old non-Roma health visitor with one child, noted when explaining her decision to seek private antenatal care:

One would need to be a millionaire in time and have nerves of steel... it's not realistic today that a working woman spends half a day waiting in line, or calls for weeks just to get an appointment.

Against this background, bricolage was also driven by the anticipation or experience of mistreatment, which many women perceived as a systemic risk rather than an exception. Narratives of neglect, poor communication, and not being taken seriously circulated widely and shaped expectations even before birth. Dina, a thirty-one-year-old non-Roma university student with two children, framed birth through a transgenerational narrative as a dangerous and dehumanising event. Her grandmother warned her during her first pregnancy: “It’s a slaughterhouse, my child, you will perish there.”

Experienced mistreatment was closely tied to a sense of vulnerability and diminished capacity for self-advocacy. Dora, a thirty-three-year-old non-Roma office worker living in the agglomeration area, gave birth in the capital; COVID-19 restrictions added an additional layer to her experience, while the caesarean section itself strongly shaped her sense of loneliness. As she put it: “In such a vulnerable situation I can’t stand up for myself.” The fear of not being believed or taken seriously was also central. Nancy, a twenty-nine-year-old non-Roma coach

with two children who gave birth in the capital, recalled how staff initially dismissed the rapid progress of her labour:

Why am I here now? Fuck, why do you think I came to the maternity ward at two in the morning? Okay, first birth. Fine, whatever. She [the nurse] didn't take me seriously. And I said, I swear I'm about to give birth. They said, yeah, well, in a first birth it's nothing like that, so they didn't take me seriously.

For women who had more than one child, previous negative childbirth experiences sometimes became direct triggers for changing strategies in subsequent births. In these cases, bricolage was not only based on anticipated risk, but on the embodied memory of earlier obstetric encounters.

Racialised and intersectional mistreatment, which in this sample exclusively affected Roma women, emerged as another motivation for anticipatory bricolage. Roma women described not only direct encounters with disrespectful or dismissive treatment, but also a broader expectation of unequal treatment that shaped their strategies even before entering healthcare settings. As Kloe, a thirty-two-year-old Roma homemaker with three children, living in a disadvantaged village in Northern Hungary summarised: “All Roma women fear prejudice.” At this stage of the analysis, the point is not yet to examine the full stratification of bricolage, but to show that for Roma women the anticipation of prejudice itself could become a reason to prepare, adjust, and seek protection before birth.

Fear of physical pain constituted a further motivation. Decisions regarding pain management, such as the use of epidural anaesthesia or opting for caesarean section, were often framed through a dual logic of self-preservation and responsibility towards the baby. As Gina, a thirty-six-year-old non-Roma anaesthesiologist who gave birth in the capital, explained: “There was one thing I feared: the pain... if I can ease it, why should it hurt?” Here, the management of pain became part of a broader effort to minimise risk in a context perceived as unpredictable. Sophie preferred caesarean delivery not only because of pain but also to minimise risk for her baby:

I had already said, even before I was pregnant, that this is what I would probably want. [...] So it is not really about me – to be honest, I don't care about that part. What matters is that the baby is safe.

The overarching motivation behind bricolage was the pursuit of a “good birth experience” for both mothers and babies, shaped by prior knowledge, previous experiences, and stories circulating through social and professional networks. However, these motivations did not

translate directly into uniform strategies. Rather, they were mediated by locally available resources, financial means, social support, professional knowledge, and structural constraints.

5.5.2. Forms of bricolage

Having outlined the motivations behind women's resource mobilisation, this section turns to the concrete forms these efforts took in practice. Following the adapted healthcare bricolage typology, the analysis focuses on three main forms: added-to-system bricolage, within-system bricolage, and alternative bricolage. These categories should not be read as entirely separate or mutually exclusive pathways, but as analytical types that capture different ways of assembling care around childbirth.

5.5.2.1. Added-to-system bricolage

The most visible form was added-to-system bricolage, through which women supplemented public maternity care with additional resources in order to gain predictability, information, and a greater sense of control. Before 2021, this often meant relying on a chosen obstetrician and informal payments within the public system. However, the interviews also show that the chosen-obstetrician model did not simply disappear after the reform. The cases of Mona, a twenty-eight-year-old Roma shop assistant with two children from a better-off, middle-class family living in a city in Northern Hungary, and Lina, a twenty-two-year-old Roma nail technician with one child, also living in a city in Northern Hungary, illustrate how, in some situations, it continued to operate as a way of securing continuity and preferential access within public obstetric care.

Mona, who gave birth in a hospital in Northern Hungary, described choosing an obstetrician as a response to vulnerability: "It is better to be in good hands in a situation like this, especially when you are so vulnerable." Her account shows how the chosen doctor arrangement created a channel of access within public care:

Basically, I either went after office hours so I didn't have to wait, or she told me to call when I arrived and then she would see me out of turn. The assistant would come out and notify her.

In this case, added-to-system bricolage did not simply mean purchasing a private service; it reorganised access to the public system by creating a personalised route through it.

Nevertheless, having a chosen obstetrician did not fully protect Mona from stigmatisation. She reported repeated delays before surgery:

And listen, they prepared me like three times before I finally got into the operating room. Because, as I'm saying, they didn't exactly love my doctor – they kept pushing someone ahead to the operating room who wasn't her patient.

She described hospital staff questioning her caesarean section and implying that women who paid a particular doctor could choose an “easier route”. Mona rejected this characterisation, emphasising how painful her recovery had been. The episode shows that paid doctor choice was visible within the hospital and could itself become a basis for judgement.

Lina's narrative shows how having a chosen obstetrician was understood as protection against being left unattended. She explained that she chose this route “because I knew that if you don't have a doctor, they leave you there to suffer.” After arriving at the hospital, she compared her own treatment with that of another woman: “...they put me straight into the delivery room. They treated me completely differently than they treated her.”

These examples suggest that, even after the criminalisation of informal payments, some women continued to seek chosen-doctor arrangements within public care. Rather than disappearing, the practice could work by creating a semi-formal or informal route through public care, where payment, personal connection and professional presence shaped access. However, these arrangements could also expose women to judgement within public care. In both Mona's and Lina's cases, having a chosen obstetrician the post-2021 landscape became visible to hospital staff and was associated with judgemental comments, partly because the arrangement was linked to doctors' continued informal or illegal practices. Lina was also aware that such arrangements were illegal: “Yeah, well, I've heard that people have even gone to prison for this already.”

A more common and formally legal arrangement was the combination of private antenatal care with public birth. This was the case for several women, including Nancy, Britney, Susy, Gina and Sophie, who used private antenatal services while planning or eventually giving birth in public hospitals. These hybrid constructions functioned as ways of compensating for the lack of continuity in public care and of securing more personalised guidance. Importantly, private antenatal care did not guarantee the private doctor's presence at birth. Instead, it often provided information, reassurance and practical knowledge about how to enter and interpret the public hospital system. As Gina explained about her private doctor: “I told her to tell me everything, it doesn't have to do anything with that I'm a doctor.” In this sense, private care was valued not only as a medical service, but also as a channel of institutional reassurance.

Beyond private antenatal care, added-to-system bricolage also involved smaller-scale paid services and forms of preparation that supplemented rather than replaced public provision. These additions included private genetic ultrasound scans, paid antenatal courses, and NGO-based preparation workshops. These additional resources did not necessarily remove women from public care, but they enabled women to enter it with greater informational preparedness, confidence and perceived control.

5.5.2.2. Within-system bricolage

A second pattern was within-system bricolage, where women relied primarily on resources available within or around public care. These strategies served several related purposes: making public care more legible through preparation and information, securing additional support within it, and protecting dignity where mistreatment was anticipated. Such practices did not provide privileged access in the same way as private care, but they helped women make the public system more manageable and less opaque.

Hospital-based birth preparation sessions were an important but ambivalent resource. They offered some orientation and familiarity with institutional routines, yet several women felt that they did not prepare them for unexpected or complex situations, especially caesarean section, breastfeeding difficulties or the emotional experience of being alone in hospital. Dora, a thirty-three-year-old non-Roma office worker with one child, living in the agglomeration area, described this ambivalence clearly:

As it turned out later, even that wasn't enough... it was very practical and good, and it gave me a little confidence so that when I was alone in the hospital I wasn't completely lost. But my son had such specific problems with breastfeeding that nothing could have prepared me for that... nor for what awaited me in the hospital.

Digital self-research was especially important in translating medical language and preparing for labour. As Tina, a thirty-two-year-old non-Roma pathologist with one child, living in the capital, put it: "I've watched some of these tutorial videos... I suddenly realised that I didn't know what those words meant."

Beyond making care more legible, birth companions played a central role in providing emotional safety, particularly in situations where institutional support was experienced as limited or inconsistent. In several accounts, companions did not simply provide emotional support; they also compensated for missing institutional attention, helped women interpret what was happening, and sometimes stretched hospital rules in order to secure continuous presence. Tina's sister, for example, hid in a closet in order to remain with her overnight,

circumventing hospital rules that would otherwise have interrupted this support. In this sense, within-system bricolage was less about buying access and more about making public care legible, bearable, and emotionally safer. What these accounts share is that the work of coordination was carried out by women and their companions rather than by the institution: continuity and reassurance were produced informally, at the margins of formal provision, and often by bending its rules.

Within-system bricolage could also serve a more explicitly protective function. For some Roma women, this involved anticipatory practices aimed at reducing the risk of humiliation or discriminatory treatment. These included managing appearance, washing before going to hospital, staying at home longer during labour, or relying on family presence where possible. These practices did not provide privileged access, but they functioned as dignity-preserving strategies within a system where disrespect was anticipated. While this theme is developed further in the next section, within-system strategies were not only informational or emotional; they could also be defensive responses to expected judgement. This also points to the limits of within-system bricolage: although women could make public care more navigable, these strategies rarely changed the underlying institutional conditions or hierarchies they had to face.

5.5.2.3. Alternative bricolage

Finally, a smaller number of women pursued alternative bricolage, meaning forms of care located largely outside the public hospital system, most notably private birth or preparation for home birth. These strategies represented the most far-reaching attempt to secure safety, autonomy, and a humane birthing environment, especially after previous negative experiences.

Maria, a thirty-two-year-old Roma PhD student with one child, living in the capital, who gave birth to her first child in a private institution, described this choice in explicitly emotional and practical terms: “It was very important for me, how should I put it, that being in private care gave me a sense of security.” In such cases, bricolage entailed not merely supplementing the public system, but partially or fully exiting it. Maria’s case represents a protective and preventive form of alternative bricolage: she chose private birth not after a previous public-sector birth experience, but in order to avoid the vulnerability and potential mistreatment she associated with public healthcare encounters.

Dina’s case shows a different route into alternative bricolage. After a traumatic first birth in a public hospital, she decided that her second birth would take place outside the public system. As she put it: “I knew that I would not set foot in a state hospital again.” In this case,

private birth was not primarily a preventive strategy, but a response to previous harm and an attempt to avoid its repetition. Dora was also preparing for an alternative pathway after a highly negative first birth in public care. She planned to combine public antenatal care with giving birth in a private hospital, hoping for a more humane environment and the possibility of a vaginal birth after caesarean section.

As part of this alternative pathway, Dora aimed for a VBAC (vaginal birth after caesarean) following her previous planned caesarean due to medical issues:

Looking back I regret a bit that I didn't stand my ground more, that I should have said I don't want this anyway. But back then I really didn't know there was another way. Or that another way was even possible.

However, alternative bricolage did not always mean complete control. Brenda, a twenty-four-year-old non-Roma doula with one child, living in the agglomeration area, had prepared for a home birth but eventually gave birth in public care after her labour lasted longer than the legally permitted timeframe for home birth. She recalled the moment when the possibility of home birth collapsed: "What else is needed? Seriously [...], home birth is just completely off?" Her case shows that even carefully planned alternatives could be interrupted by regulatory conditions, timing, and the contingencies of labour. Alternative bricolage therefore represented the strongest attempt at exit, but not necessarily a fully secure or fully autonomous pathway.

Taken together, these forms of bricolage show that bricolage operated along a spectrum, from supplementing public care to selectively navigating it, and in some cases leaving it behind altogether. While the specific combinations differed, all three forms reflected women's active efforts to reconstruct continuity, information, and support in a fragmented maternity care system. The typology also prepares the ground for the following section: these forms were not equally accessible, and their effectiveness depended on women's financial resources, knowledge, social networks, geographical location, and racialised position within care encounters.

5.5.3. Stratified bricolage and the limits of money

These forms of bricolage appeared across the sample, but they were neither equally accessible nor equally effective. The ability to mobilise particular forms of care depended on women's social status, financial resources and racialised position within healthcare encounters. At the same time, access to more resource-intensive forms of bricolage, especially those involving private care, chosen doctors or hybrid arrangements, was strongly shaped by financial capacity. Several women described situations in which preferred options were ruled out because of cost,

indicating that even partial access to more predictable care arrangements could be financially unattainable. Kira, a forty-one-year-old Roma homemaker with four children, living in a city in Northern Hungary, for example, considered the possibility of having a chosen obstetrician, but the quoted price made this strategy inaccessible. In other cases, families mobilised additional labour or support to make such arrangements possible. Lina mentioned that her partner had to work abroad to finance these costs. These examples show that added-to-system bricolage required not only motivation, but also the capacity to convert money, family labour and social support into access.

However, within-system bricolage should not be understood as an equally accessible or cost-free fallback. With the exception of Maria and Renata, none of the Roma participants in this sample attended official birth preparation, a pattern suggesting unequal access even to formally free or low-cost resources. The interviews do not allow this difference to be attributed to a single cause, but information gaps, practical constraints and different orientations towards formal preparation may all have mattered. Hospital choice could also depend on usable social and professional connections: Dora transferred to another hospital through an acquaintance so that she would know the doctor performing her planned caesarean, while Sophie was able to aim for a hospital outside her district because of her professional affiliation as a health visitor. Within-system bricolage therefore generally required less direct financial investment, but still depended on informational, relational, temporal and geographical resources that were unequally distributed.

Financial resources therefore expanded women's room for manoeuvre, but the advantages they provided were partial and uneven. While they could expand the range of available options and facilitate more personalised care, they did not fully eliminate uncertainty or guarantee respectful treatment. For some women, money clearly appeared to improve access and attention. Lily observed: "They speak more specially to those [who pay], and they attend to them more, because the last time I gave birth, I was with someone who had a chosen doctor." Yet she also questioned the extent to which money could fundamentally transform the embodied experience of birth or remove vulnerability:

Now I give birth the same way as someone who hands over the money. She's in the same pain as me. Let's be honest, sure it's good, because they give her medicine and they don't give that to me. But it hurts her the same way it hurts me.

This highlights the limits of money as a resource within a fragmented system: it could buy attention, speed or pain relief, but it could not fully remove dependence on institutional actors

or the bodily vulnerability of childbirth. Lily's juxtaposition is analytically telling: she distinguishes between what money can redistribute, attention and pain relief, and what it cannot, the shared bodily exposure of birth.

Mona's case further illustrates this ambivalence. Her chosen obstetrician created preferential access and a personalised route through public care, yet it did not protect her from moralising comments by hospital staff. After her caesarean section, she recalled staff members asking: "And why did they perform a caesarean on you, and who is your doctor? [...]" And then they say to each other: Another caesarean, because she was too lazy to give birth." Here, payment and doctor choice did not simply secure better care; they also became visible within the hospital and could trigger judgement about deservingness, bodily effort and the legitimacy of caesarean birth. This suggests that money could reorganise access but not necessarily erase the moral and racialised hierarchies through which women were interpreted. Kloe added that social status also mattered, not just being Roma: "There are families who are very well-off... they speak nicely to them... whether they are Roma or not."

Yet financial resources and social status were only part of the stratification of bricolage. Racialisation also shaped both women's experiences of obstetric care and their anticipatory tactics for navigating the system. For Roma women, negative expectations were not limited to childbirth itself but were often rooted in earlier healthcare encounters and in broader experiences of being judged through racialised assumptions. As Maria recalled from her childhood experiences a medical examination: "They spoke to my mother – and to me as well – in a rude and disrespectful way... they were not thorough enough." Such accounts were not perceived as isolated incidents, but as part of a wider pattern in which Roma women expected to be seen, evaluated and treated differently within healthcare institutions. This pattern was also linked to appearance, cleanliness and moral judgement. Although Kloe herself had not been directly targeted, she recalled one of her hospital stays: "Thank God they haven't looked down on me, but they did to my roommate, she was very young, and they shouted at her."

Lily, a twenty-three-year-old Roma homemaker, reported that during her second birth the Roma woman next to her was told: "stay quiet, or you won't be checked." Another woman was criticized for her artificial nails, being told that they were dirty. Later, during her third birth, Lily herself also received a remark: "He [the doctor] was sly, because he kept saying why I was giving birth to so many children." Beyond the individual encounter, this remark evokes a broader racist stereotype portraying Roma women as having "too many" children and reproducing "irresponsibly."

At the more resource-intensive end of the typology, private birth offered the strongest possibility of exit from public obstetric care. For Maria, this was explicitly connected to racialised vulnerability. Reflecting on her broader healthcare practices, she stated: “It is a very ugly thing that somehow you have to buy kindness and normal treatment, despite – God forbid – being Gypsy.” Her account shows that private care was not understood merely as a consumer preference or a search for comfort, but as a way of trying to purchase dignity, kindness and credible treatment in a context where these could not be taken for granted.

Yet even the possibility of exit was unevenly distributed. Private birth, private antenatal care and chosen-doctor arrangements required substantial financial resources, geographical access and knowledge about available options. For women with fewer material resources, within-system bricolage often remained the only realistic strategy, even when public care was precisely the setting where humiliation or neglect was anticipated. In this sense, the most protective forms of bricolage were also the least equally accessible.

For women who remained dependent on public care, however, the limits of bricolage became particularly visible in encounters shaped by racialised and classed judgement. Kendall, a forty-two-year-old Roma homemaker with seven children, living in a disadvantaged village in Northern Hungary, offered the most condensed formulation of the intersectional dynamic of childbirth. During one of her own births, she overheard a healthcare worker telling another Roma woman: “go wash your cunt, lady, because you stink like a dog.” Based on her own and her relatives’ experiences, she concluded: “I am angry with healthcare because, if you allow me, money talks. Roma-ness, being a Roma and appearance talk. No matter what.” These examples point to an intersectional dynamic in which ethnicity, socio-economic position and appearance were read together within healthcare encounters.

Hope, a twenty-seven-year-old Roma homemaker, offered an even more nuanced observation: “...it depends on what you get, some people are gypsy haters/racists, however you're dressed.” Lily’s impression added another layer to this lack of uniformity: “If you happen to get a decent doctor, they speak nicely to you, but the older ones who have been there for a long time can really talk back at you.” Her account suggests that generational differences may shape medical staff’s attitudes toward Roma patients. The unpredictability itself is consequential: because respectful treatment depended on which individual staff member a woman happened to encounter, dignity became a matter of chance rather than entitlement, and anticipatory bricolage a rational response to that arbitrariness.

Women’s ability to secure continuity, information and respectful treatment depended not only on their motivations or efforts, but also on their position within broader social

hierarchies. Bricolage, therefore, should be understood not simply as individual resourcefulness, but as a practice shaped and constrained by structural inequalities. Money could “talk” in Hungarian obstetric care: it could buy time, access, comfort, the privilege of accessing private information, and sometimes continuity. However, it did not speak equally loudly for everyone, and it did not necessarily buy protection from racialised judgement, institutional vulnerability or disrespect. The typology therefore reveals unequal room for manoeuvre rather than a set of equal choices.

5.6. Discussion

This chapter has examined how women navigate obstetric care in a hybrid healthcare system undergoing institutional transformation. The findings suggest that what might appear as freely chosen individual strategies of combining care are better understood as structurally shaped practice emerging in response to uncertainty, fragmentation, and unequal access to supportive care (Gaal *et al.* 2021; Kisdi and Földházi 2024). The analysis has shown that women’s bricolage practices were oriented towards securing conditions that should be ordinary features of childbirth care: predictability, continuity, communication, and respectful treatment (WHO, 2018, 2025; Fisher *et al.*, 2019).

Women were not simply choosing between available options; rather, they were required to actively construct care pathways. In this sense, bricolage represents not the expansion of choice, but the redistribution of responsibility, whereby the burden of making care “workable” is shifted onto patients. These findings point to several broader contributions of the chapter.

First, the findings contribute to the literature on healthcare bricolage (Phillimore *et al.*, 2019b). While previous research has emphasised how individuals creatively combine resources, this study shows that such practices are often driven by the need to compensate for institutional shortcomings. Bricolage, in this context, is less about flexibility and innovation, and more about managing risk, uncertainty, and potential harm.

Second, the analysis demonstrates how institutional reforms can coincide with new forms of uncertainty that reorganise access to care. In the accounts analysed here, the 2021 reform did not appear to create or abolish bricolage but was associated with a shift in its logic. For many women, it was experienced as removing a previously available informal mechanism of continuity, while in some cases chosen-doctor arrangements persisted through more discreet, semi-formal or illegal practices. At the same time, the work of securing predictability appeared to shift towards other hybrid arrangements, most visibly private antenatal care combined with

public birth, alongside informal knowledge, birth preparation, companions and social support (Gaal *et al.*, 2021; Kisdi and Földházi, 2024).

The forms of mistreatment described in the interviews broadly align with Castro and Savage's (2019) typology of obstetric violence. Most participants, however, did not themselves use the term violence, and differed in whether they framed these encounters negatively or as routine features of care. These accounts also illuminate processes of reproductive governance: institutional interactions shaped not only clinical decisions, but also the moral interpretation of women's reproductive behaviour. Susy's account of staff describing her child as a "CSOK baby"¹⁵, for example, shows how pronatalist policy instruments can become moralising frames through which individual births and reproductive motivations are judged. Bricolage can therefore be understood partly as an attempt to anticipate or reduce these forms of institutional and moral control, and to retain greater control over information, decisions, and the birthing process.

This raises a question the material poses but cannot fully settle: is bricolage a way of evading the largely invisible workings of institutional and moral control, or is it also, increasingly, the very form of conduct that reproductive governance now expects of women? The interviews point primarily to the former. Women's practices were oriented towards evading, softening, or anticipating institutional and moral control, and in this sense, bricolage operated as a form of navigation *around* governance rather than compliance with it. Yet the same practices may also be read, more tentatively, as a mode of responsabilisation: as public institutions withdraw the coordination and predictability they once loosely provided, the work of securing them is quietly reassigned to women and their families. These readings need not be mutually exclusive. The point is not that bricolage has been fully absorbed into governance, but that the space it opens is an ambivalent one, offering a measure of control while also individualising institutional responsibility. And, as the stratification of bricolage shows, even this space is unequally available, narrowest for those whom money and effort cannot shield from racialised judgement. Read this way, bricolage begins to appear not only as a response to reproductive governance but as one of the everyday sites where it may be quietly reworked, and where its unequal terms surface, a thread the conclusion returns to.

Third, the findings highlight how inequalities in obstetric care are reproduced and negotiated through everyday practices of navigating the healthcare system. Bricolage operated

¹⁵ "CSOK baby" is an informal, derogatory expression referring to a child perceived as having been conceived or born primarily for the purpose of accessing the Family Housing Allowance (CSOK), a state housing support scheme offering financial benefits based partly on the number of existing or planned children.

as a stratified process: while all women engaged in some form of resource mobilisation, the range and effectiveness of available forms varied significantly across social positions. Financial resources expanded the scope of possible arrangements, particularly through access to private services; however, they did not fully eliminate exposure to institutional fragmentation or guarantee respectful treatment (Szabó and Veroszta, 2024). From an intersectional perspective, these findings suggest that inequalities operate not only through differential access to resources, but also through their unequal effectiveness: financial resources, knowledge, or social connections do not necessarily provide the same degree of protection or room for manoeuvre across differently positioned and racialised women.

Added-to-system and alternative bricolage were more available to women who could mobilise money, knowledge, family labour, professional familiarity, or geographical access to private services. Within-system bricolage was more widely available but often offered weaker protection because it relied on making public care more navigable rather than changing the institutional conditions of care itself.

Those solutions that remained within the public system generally required less direct financial investment; at the same time, they demanded considerable personal investment in time, effort, emotional energy, and perseverance. This helps clarify why within-the-system strategies can be “expensive” even when they are formally low-cost.

The findings further highlight the role of racialisation in shaping not only experiences of care, but also women’s possibilities for navigating the system. While paying for services could sometimes improve access to information, predictability, or perceived safety, it did not reliably protect Roma women from humiliating remarks, disbelief, or degrading moral judgements. This pattern resonates with prior research on unequal care for Roma women (Szabó and Veroszta, 2024; Balogh-Szabó, 2023; Kóczé, 2020) and underscores that stratification in obstetric care is simultaneously classed and racialised. Money could “talk” in obstetric care by buying time, access, information, comfort, or partial continuity. Yet it did not speak equally loudly for everyone, and it did not necessarily protect women from racialised judgement, moralising interpretations of motherhood, or the vulnerability of being dependent on public institutions at critical moments of childbirth. The possibility of “exit” into private care also remained structurally constrained by resources and availability, meaning that the ability to avoid discriminatory settings was itself unequally distributed. The one Roma participant who reported no such experiences had moved entirely into private care – an exception that underscores, rather than contradicts, the argument: avoiding racialised judgement appeared to require full exit from the public system, an option available to almost

none of the Roma women in the sample. Given that this rests on a single case, the relationship between private exit and protection from racialised treatment requires further investigation.

These findings suggest that bricolage should be understood as a structurally embedded and socially stratified practice, rather than an expression of individual choice or creativity alone (Phillimore *et al.*, 2019b). Although the analysis focuses on Hungary, the patterns described here are not unique. The Hungarian case makes these dynamics particularly visible, especially in light of recent reforms and the growing role of private care, but similar challenges around fragmentation, uncertainty, and navigating between public and private provision are present in many healthcare systems (Bradby *et al.*, 2020; Liamputtong, 2005).

The broader implication is that healthcare bricolage should not be understood primarily as resilience or empowerment. It signalled the displacement of institutional responsibility onto women and families. A system in which patients must assemble continuity, dignity and information for themselves risks turning unequal resources into unequal care.

5.7. Conclusion

This study has shown that navigating childbirth care in Hungary requires women to actively assemble their own pathways across a fragmented and hybrid system. What appears to be an individual choice is, in practice, a necessary response to uncertainty, lack of continuity, and uneven access to supportive care. The analysis also shows that bricolage is necessary but stratified, that is, classed and racialised. While all women in the sample mobilised some form of resource, they did not do so under equal conditions. More resource-intensive forms of bricolage were more available to women with greater financial, informational and relational resources. For others, making care workable depended on more limited within-system bricolage, including self-research, public preparation, family support, or dignity-preserving adjustments in anticipation of mistreatment.

In this sense, bricolage can also reproduce inequality: those with more resources are better able to withdraw partially from public care, purchase continuity or access more protective arrangements, while those with fewer resources remain more exposed to the institutional uncertainties and hierarchies that make bricolage necessary.

Read in this way, women's bricolage practices are not only responses to institutional fragmentation; they render reproductive governance observable. What women assemble, avoid, and endure shows how demographic ambitions, pronatalist moral framings, and medical authority are enacted, negotiated, and stratified at the level of everyday obstetric encounters. Bricolage is where the governing of reproduction becomes concrete, and where its unequal

terms, most sharply along classed and racialised lines, become visible. The 2021 reform did not lift this governance; it reorganised the terrain on which women must do this work and redistributed the burden of making care workable onto them.

Improving childbirth experiences, therefore, cannot rely on expanding individual options alone, but requires addressing the systemic conditions that make such navigation necessary in the first place. The goal cannot be a system in which women's safety, dignity and sense of control depend on their purchasing power, social networks, health-related knowledge or racialised deservingness. Rather, the findings point to the need for generally accessible, predictable and respectful obstetric care in which the basic conditions of a good birth are not something women have to assemble for themselves.

6. DISCUSSION AND CONCLUSION

This dissertation has explored the structural and experiential dimensions of childbirth in Hungary, focusing on a fundamental tension between macro-level demographic goals and micro-level experiences of care. Through the lens of reproductive governance (Morgan and Roberts, 2012; Castro and Savage, 2019), it is evident that while the Hungarian state pursues a strong selective pronatalist agenda (Szikra, 2018a, 2018b; Szalma and Pélyi, 2025) framing childbearing as a “patriotic duty” and a solution to a “demographic crisis”, it simultaneously fails to provide a consistent, respectful, and predictable institutional environment for the act of birth itself (Szabó 2017, 2021). This selective pronatalism privileges “worthy,” traditional family models while leaving some of the actual conditions of childbearing, particularly obstetric care, fragmented and unequal.

The three studies approach this tension from different angles, and their findings are most persuasive read together. The scoping review ([Chapter 3](#)) established that the socio-economic patterning of childbirth experiences is not a Hungarian peculiarity but a recurring international finding: across OECD countries, women in less advantaged social positions are more exposed to negative experiences, although the direction and strength of these associations vary and the institutional mechanisms behind them remain under-examined. The two Hungarian studies then specify what these international patterns look like in one hybrid, post-socialist system, and trace the mechanisms the review could not. The survey ([Chapter 4](#)) locates the inequality at the level of population-wide perceptions and satisfaction; the interviews ([Chapter 5](#)) show the everyday work through which it is produced and managed. The Hungarian case thus operates as a detailed instance of a broader pattern, while contributing the institutional and experiential detail that quantitative international research tends to leave unspecified.

Taken together, the findings can be interpreted as consistent with a moral regime in which some degree of suffering and patient compliance is normalised (Morgan and Roberts, 2012). As seen in the Dominican Republic case study (Castro and Savage, 2019) and echoed in the Hungarian context, some accounts suggest processes resembling adaptive preference, accepting disrespectful care or poor hospital conditions as part of the process. This normalisation is a central mechanism of reproductive governance, where the state and medical institutions maintain stratified standards of care that vary significantly based on a mother’s social and racialised position. However, through bricolage women try to question the norm of mistreatment in different forms.

The 2021 healthcare reform, which criminalised informal (gratitude) payments (Gaal *et al.*, 2021; Veroszta and Szabó, 2021), represents a critical turning point in this governance. While the reform aimed to increase transparency and eliminate the “dual practice” within the public sector, [Chapter 4](#) shows that respondents who gave birth after 2020 reported significantly lower satisfaction than those who gave birth in earlier periods. This dissatisfaction may reflect the loss of the “chosen obstetrician” model, which previously provided women with a sense of continuity and predictability, albeit through an informal and unequal financial mechanism (Kisdi and Földházi, 2024).

In the post-reform landscape, care in the public system is determined by whoever is on duty rather than by a chosen obstetrician, which – according to some experts as well (Interviewee 1 & 3) – may actually result in better experiences than having a chosen obstetrician who might rush the birth process. However, as [Chapter 4](#) highlights, financial factors, including access to private obstetricians, remain a salient dimension of public perceptions of how “better care” can be secured.

The qualitative findings in [Chapter 5](#) shift the focus to how women navigate this fragmented system through healthcare bricolage (Phillimore *et al.*, 2015, 2018, 2019a, 2019b). Rather than treating these practices primarily as expressions of individual choice or consumer agency, the findings show how bricolage can emerge as a response to institutional uncertainty, fragmentation, and anticipated mistreatment. What matters at the level of the dissertation is therefore less the distinction between individual forms of bricolage than the fact that both the need for these strategies and the resources through which they can be pursued are socially stratified.

A crucial finding of the qualitative analysis, with broader implications for the dissertation, is the intersectional nature of obstetric inequalities, particularly regarding Roma women. The qualitative data reveal that while financial resources can “buy” certain forms of comfort or access, they do not reliably protect Roma women from racialised mistreatment within public care. Roma mothers reported derogatory comments, disbelief of their physical pain, and moralising judgments about their childbearing regardless of their ability to pay in line with previous research (Balogh and Geller, 2019; Balogh, 2025; Bodrogi, 2016). This demonstrates that access to financial resources does not necessarily protect women from racialised treatment, as the returns to these resources may themselves be shaped by racialised institutional encounters.

Taken together, the dissertation makes three main contributions. Empirically, it provides a multi-method account of inequalities in childbirth care by connecting international

evidence on the socio-economic patterning of childbirth experiences with population-level patterns of satisfaction in Hungary and qualitative accounts of women's everyday navigation of obstetric care. In doing so, it demonstrates that socio-economic inequalities in obstetric care manifest not only in access and experiences, but also in the everyday work women may need to perform to secure predictability, information, continuity, recognition, and respectful treatment.

Conceptually, the dissertation extends healthcare bricolage to childbirth within a formally universal healthcare system and highlights its ambiguous relationship with reproductive governance. Bricolage may provide women with ways of regaining some control over their reproductive experiences, but it does not necessarily operate in opposition to governance. When navigating, combining, and supplementing care become normalised or even expected, the responsibility for managing institutional shortcomings may instead be shifted onto individual women. In this sense, bricolage makes reproductive governance observable not only through formal policies and institutional arrangements, but also through the individualised work required to navigate them.

Finally, the dissertation brings reproductive governance, intersectionality, and healthcare bricolage into a common analytical framework. Reproductive governance identifies the institutional, policy, and moral arrangements through which childbirth is organised; intersectionality draws attention to women's differentiated positions within these arrangements; and healthcare bricolage makes visible how these conditions are encountered and negotiated in everyday care trajectories. This integration shows that inequalities concern not only differential access to resources, but also women's unequal capacity to convert apparently similar resources into protection, recognition, and room for manoeuvre. It also helps illuminate the seemingly tension-filled relationship between the macro-level demographic goals and the micro-level experiences of childbirth: how can a society promote the birth of children while failing to ensure positive and respectful birth experiences?

6.1. Strength and limitations

A key strength of this dissertation lies in the combination of its multi-method research design. By bringing together a scoping review, a survey-based quantitative analysis, and in-depth qualitative interviews, the dissertation connects international evidence on socio-economic patterning in childbirth experiences to the specific institutional dynamics of Hungarian obstetric care and women's individual navigation strategies. This research maps established patterns and debates while also capturing the lived experience of navigating care under

conditions of institutional fragmentation and uncertainty. The three methods provide complementary perspectives rather than directly validating the same findings through conventional mixed-methods triangulation.

The dissertation's empirical materials add value in two further ways. First, the qualitative component provides rich insight into how women interpret and manage uncertainty in obstetric care, and how strategies for a "good birth" are shaped by unequal resources. Including Roma and non-Roma mothers with different social backgrounds strengthens the dissertation's capacity to address inequalities as stratified and intersectional. Second, the expert interviews, although limited in number, support contextualisation and triangulation by illuminating system-level mechanisms and recurring institutional constraints of obstetric care. They are not treated as a separate empirical study, but as contextual material that supports the interpretation of the main findings.

A further strength is the dissertation's conceptual contribution. By using the frameworks of reproductive governance and healthcare bricolage, the dissertation explores the tension between macro-level demographic goals and micro-level childbirth experiences: the apparent contradiction whereby a society promotes childbearing while failing to ensure positive, respectful, and predictable birth experiences. Conceptually, reproductive governance helps link population-level rationalities and moral regimes to institutional arrangements, while bricolage captures how women encounter and negotiate these arrangements in everyday care trajectories. This combination also facilitates dialogue with international scholarship: many patterns identified in the Hungarian case closely resemble mechanisms documented elsewhere, thereby strengthening the dissertation's broader relevance.

The scope of the dissertation is nevertheless deliberately selective. It examines childbirth primarily as a social process, focusing on inequalities, governance, women's experiences, and the everyday work involved in making care pathways more predictable and manageable. It does not provide a comprehensive evaluation of the Hungarian obstetric system, nor does it assess clinical outcomes, the medical appropriateness of particular interventions, or the overall performance of individual institutions. The empirical analysis is mainly based on women's accounts. The perspectives of healthcare professionals, partners, and other family members are not examined systematically, even when they appear indirectly in the interviews or contextual materials. Furthermore, although the dissertation adopts an intersectional perspective, its empirical analysis concentrates mainly on socio-economic position, education, place of residence, and the racialisation of Roma women. Other potentially relevant

dimensions, including disability, migration background, sexuality, and different family forms, could not be analysed with the same depth.

The article-based structure also places limits on the dissertation. The three studies were developed with different research questions, samples, methods, and temporal perspectives, rather than as sequential components of a single mixed-method study. They do not examine the same participants or events, and the concepts at their centre – childbirth experience, satisfaction, healthcare bricolage – are related but not interchangeable. Their integration therefore takes place at the level of the dissertation through an analytical synthesis, rather than through the direct comparison or validation of identical findings. This structure makes it possible to connect different levels of analysis, but it also inevitably entails some repetition of theoretical arguments, contextual information, and key concepts across chapters. Such repetition is partly inherent in the article-based format, as the individual studies were originally developed as self-contained pieces while also contributing to the overarching argument of the dissertation.

The dissertation also has several limitations. First, the qualitative study is not representative, and its aim is not to estimate prevalence or population-level effects. Instead, the qualitative material identifies mechanisms, meanings, and patterned strategies under shared institutional conditions. The purposive and largely snowball-based recruitment process may have produced selection and network biases, as women who were willing to discuss their experiences or who were connected to particular organisations and social networks may have been more likely to participate. Although separate recruitment routes were used to broaden the sample, they cannot eliminate these biases. The heterogeneity of the sample enabled the study to explore a wide range of trajectories and resources, but it also limits strict comparisons between social groups. In particular, the small number of Roma participants with substantial educational and financial resources constrains the conclusions that can be drawn about how socio-economic status and racialisation interact. The financial costs of different strategies were also not recorded systematically, which prevents a precise comparison of their material burdens.

Second, the expert interviews are small in number, relatively homogeneous, and were not designed as an independent study with systematic sampling; they are therefore best understood as contextual material provided by key informants, complementing the literature and the main empirical studies. The translation of the interviews posed additional challenges, as they were originally conducted in Hungarian. Preserving the intended meaning as accurately

as possible was a key priority; however, it is still possible that very subtle linguistic codes and culturally specific meanings were lost in translation.

Each method also carries its own constraints. The scoping review maps available evidence, but its scope and inclusion criteria (e.g., timeframe, location) mean that gaps in the international literature may reflect both true absences and uneven research attention. The review was restricted to English-language journal articles published between 2013 and 2024, identified through Scopus, Web of Science, and PubMed, and concerned only OECD countries. Grey literature, non-English publications, and research conducted outside OECD settings were therefore excluded. The final body of evidence consisted of 18 conceptually and methodologically heterogeneous studies. Moreover, the selected search terms foregrounded socio-economic position and childbirth or maternal experiences. Relevant studies using other conceptual vocabularies – for example, respectful maternity care, obstetric violence, discrimination, or racialised care – may not have been identified. The apparent underrepresentation of qualitative perspectives, minority women’s experiences, and institutional mechanisms may consequently indicate both a substantive research gap and a limitation produced by the search strategy. As a scoping review, the study maps the available field rather than assessing effect sizes, comparing healthcare systems systematically, or determining which findings are supported by the strongest evidence.

The survey-based analysis is cross-sectional and relies on self-reported experiences and perceptions, which can be shaped by recall, expectations, and social norms. Although the survey used a nationally representative sample, the analyses of personal childbirth experiences rely on a smaller analytical subsample, particularly in relation to births occurring after 2020. The study includes recollections of events that took place in very different historical periods, and the time elapsed since childbirth varies considerably between respondents. The period of childbirth is also closely connected to respondents’ age, generation, changing expectations, and broader transformations of the healthcare system. Consequently, the differences identified between childbirth periods cannot be interpreted as longitudinal change. Nor can the lower satisfaction reported after 2020 be attributed causally to the 2021 reform, particularly because the reform coincided with the COVID-19 pandemic and other institutional changes.

Satisfaction was measured through a single subjective item and was subsequently transformed into a binary outcome for the regression analysis. This supported model stability, but it reduced the distinctions contained in the original four response categories. Satisfaction is also not equivalent to clinical quality, safety, or an unambiguously positive childbirth experience. It can be shaped by expectations, adaptive preferences, previous encounters with

healthcare, and retrospective reinterpretation. Satisfaction measures can nevertheless provide valuable information for the organisation and development of maternity care, but they should be interpreted cautiously and alongside other forms of evidence. Relying on satisfaction alone may obscure shortcomings in care, as women's evaluations are partly shaped by the forms of care they have previously experienced and come to regard as normal or expected (van Teijlingen *et al.*, 2003). In addition, the survey did not include all potentially relevant clinical and institutional factors, including detailed information on complications, interventions, place of birth, or mode of delivery. The findings should therefore be interpreted as associations between the measured characteristics and reported satisfaction, rather than as a comprehensive explanation of childbirth experiences.

Finally, the qualitative material depends on narrated experiences and retrospective sense-making; while this is analytically valuable for understanding meaning and strategy, it is not equivalent to direct observation of institutional practice. Also, possible selection bias and the characteristics of the sample introduce several additional limitations. The interviews were conducted in different settings, including online and face-to-face interviews, and in some cases in the presence of family members. These settings may have shaped what participants felt able or willing to discuss, although they also provided insight into the social environments in which the experiences were narrated. The data collection period extended from 2022 to early 2026, with most interviews conducted in 2024. The material therefore captures experiences from different moments following the 2021 reform, but it does not constitute a longitudinal analysis of institutional change.

A further conceptual boundary concerns the relationship between healthcare bricolage and theories of capital, and represents one of the most promising directions for developing this work. Bourdieu's distinction among economic, social, and cultural capital can help clarify the kinds of resources women bring to these situations and their unequal accumulation and convertibility (Bourdieu, 1986). Forms of capital help identify what resources may be available and why they are stratified; bricolage describes how these heterogeneous resources are actually mobilised and combined within a particular, uncertain care trajectory. An intersectional perspective further shows that possession of capital does not guarantee equal institutional recognition or equal returns, since racialised credibility and institutional classification can shape whether those resources translate into effective advantage. A systematic capital-theoretical analysis lies beyond the scope of the present dissertation, which foregrounds the practical work of bricolage rather than the conversion of capital as such, but it is a direction the dissertation opens rather than closes.

There are also limits associated with the conceptual perspective adopted in the dissertation. The bricolage framework deliberately draws attention to institutional fragmentation, unequal resources, and the work women perform to secure basic conditions of care. This focus may make other interpretations less visible, including consumer orientations, changing individual preferences, and the relational or clinical unpredictability that cannot be removed entirely from childbirth. The same practice may function simultaneously as a defensive response to institutional shortcomings and as a preference-based choice, and the empirical material does not always allow these motivations to be separated clearly. Acknowledging this overlap does not, however, alter the primary interpretation developed in the dissertation: in most of the cases analysed here, bricolage was directed less towards obtaining optional or luxury services than towards securing information, continuity, dignity, and a sense of safety.

A central structural and personal limitation concerns the democratic character of knowledge production and the practical usefulness of research for especially vulnerable groups in their everyday realities. This concern is closely linked to positionality, academic knowledge production, and to the socio-political context in which the research was conducted. My position as a non-Roma, middle-class researcher without personal experience of childbirth shaped access to the field, the interview relationships, and the interpretation of participants' accounts. Bridge people and community contacts were important for establishing access and trust, but they may also have influenced whose experiences entered the research. Throughout the dissertation and from the very beginning of the research, reflexive attention to the risks of exploitative research relationships informed decisions across the process, and efforts were made to minimise exploitative hierarchies at each phase. Nevertheless, academic work primarily produces evidence and conceptual clarity, which does not in itself produce immediate material benefits or structural change in participants' everyday lives. In this sense, one practical contribution of the dissertation is to provide a robust, research-based foundation that can support the work of actors and institutions who have the resources and mandate to pursue meaningful structural change.

Taken together, these limitations mean that the dissertation cannot establish the prevalence of experiences or strategies across the Hungarian population, provide a causal evaluation of the 2021 reform, or offer a comprehensive assessment of the clinical quality of Hungarian obstetric care. It can, however, identify how inequalities become visible at different analytical levels, how institutional arrangements are interpreted and navigated in everyday life, and how the resources available for making care workable are socially stratified and racialised.

The dissertation therefore offers an account of patterned experiences and mechanisms rather than an exhaustive representation of Hungarian childbirth care.

6.2. Reflections and future research directions

Based on this dissertation and on its materials, several additional themes emerged across the studies, especially across interviews that could not be explored systematically within the scope of this dissertation but point to directions for future research. These include the role of fathers and partners during pregnancy and birth; and the burdens associated with the postnatal (hospital) period, particularly time spent in neonatal units. Interviewees also raised challenges around breastfeeding and the presence of maternal guilt, suggesting important directions for future research in the field of childbirth and childbearing in the Hungarian context.

Future work could also expand and restructure the qualitative sample. One important direction would be to include more Roma women with higher socio-economic status to better understand how racialised experiences intersect with classed resources and institutional recognition. In addition, private births and home births appeared in this dissertation partly as “extra” elements rather than as systematically analysed fields; however, they proved to be highly informative. A more targeted and comparative analysis of these care pathways could offer valuable insight into how autonomy, safety, and predictability are differently constructed across settings, and how inequalities are reproduced through stratified access to “choice.”

Methodologically, future research could benefit from deeper ethnographic engagement, including fieldwork within obstetric institutions and, where feasible and ethically appropriate, following birth journeys more closely (for example through birth accompaniment or observation). Given the centrality of online information-seeking and peer support, digital methods could also be relevant. Netnography in online pregnancy and parenting groups may help capture how knowledge, fear, and norms circulate, although such research would require careful attention to ethics, consent, and data protection.

Home birth constitutes another important and growing field for further investigation, both because of its increasing visibility and because it highlights the boundaries of institutional obstetric care. At the same time, the expert interviews conducted for this dissertation point to the value of continuing this research direction and adding to existing research: extending the expert sample, conducting follow-up interviews, and analysing these materials more systematically could strengthen understanding of institutional dynamics, professional rationalities, and perceived reform effects.

Further analyses could be developed based on accessible administrative or routinely collected data where available, and joint work with existing datasets and research groups may be particularly fruitful in a field where data access remains uneven. Furthermore, comparative studies within the European region could be a fruitful way to identify differences and similarities. Within the reproductive governance framework, it would also be valuable to examine in more detail how moralised regimes shape reproductive norms, potentially including how different fertility-related narratives, expectations, and logics become embedded in institutional practices and everyday decision-making.

Two further lines of work follow directly from this dissertation and are already in preparation. The first develops the capital-theoretical reading of the qualitative material outlined in [Chapter 6.1.](#): analysing women's bricolage through Bourdieu's forms of capital would make it possible to specify how economic, cultural, and social resources are accumulated, converted, and unequally rewarded within obstetric care, and how racialised credibility conditions their convertibility. The second is a methodological paper reflecting on the dilemmas of interviewing women from very different social backgrounds – from the most marginalised to the most privileged – within a single study, and on the comparability of accounts generated across such asymmetries of position, language, and expectation. Both extend, respectively, the conceptual and methodological contributions of the present work.

6.3. Practical implications

The findings of this dissertation may be relevant for state decision-makers, policy makers, and healthcare experts in several ways. A turbulent period of political change makes these questions especially timely: reproductive rights and issues affecting women have re-entered public and political debate, and following the 2026 change of government the newly established health ministry has signalled a willingness to rethink the organisation of reproductive regulations. Civil-society and women's-rights organisations have successfully advocated for their inclusion in this process, arguing that women's and mothers' perspectives should shape strategy.¹⁶ This context gives the dissertation's findings a concrete point of application. First, the results highlight that obstetric care is a complex field where single-point interventions are rarely sufficient; an insight also illustrated by the criminalisation of informal payments, which did not, on its own, resolve underlying systemic problems. A primary practical implication is

¹⁶ HVG (2026) 'Szüléssel foglalkozó civil szervezetek hívják Hegedűs Zsoltot személyes egyeztetésre', *HVG*, 14 May. Available at: https://hvg.hu/itthon/20260514_hegedus-zsolt-egeszsegugyi-miniszter-egyeztetes-szules-civil-szervezet (Accessed: 23 August 2026).

therefore the need for more complex, multi-point changes which include and prioritise mothers' needs and experiences in reforming the system.

Evidence-based approaches are further crucial elements to be included in the process. Beyond issuing and updating obstetric guidelines, implementation is needed and requires monitoring and accountability mechanisms. This also implies closer cooperation with relevant professional and civil-society actors, including knowledgeable stakeholders outside the state sector, who often have field-level insight into both service gaps and workable solutions, enabling the multi-point interventions that are needed.

Ideally, obstetric care should be accessible regardless of social origin and financial position. This requires reducing the informal and formal costs of childbirth and strengthening publicly funded pathways so that access to predictable, respectful, and responsive care does not depend on the ability to pay. In parallel, addressing inequalities demands investment in the infrastructure of the social fabric: communication and information provision should be strengthened already within professional training, and respectful interaction should be treated as a minimum standard rather than an optional add-on.

Finally, the dissertation points to the slow but necessary work of social and institutional change. Reducing racist attitudes and discriminatory practices in obstetric care requires targeted measures within healthcare institutions, while also acknowledging that racialisation and exclusion are broader societal problems that extend far beyond maternity wards.

Ultimately, the findings of this dissertation point back to the tension from which it began: the conditions under which children are born matter alongside demographic ambitions to encourage childbearing. A reproductive governance perspective makes visible that reproduction is shaped not only through policies that encourage or regulate fertility, but also through the institutions in which pregnancy and childbirth are experienced. Across the three studies, the dissertation shows that access to positive, predictable, and respectful childbirth care remains socially uneven, while part of the work required to secure such care is shifted onto women themselves. Healthcare bricolage can provide room for manoeuvre within these conditions, but it cannot substitute for responsive and equitable institutions. Ensuring dignity, information, continuity, and respectful treatment should therefore not depend on women's capacity to mobilise money, knowledge, social connections, or alternative pathways, but should form part of the basic conditions of obstetric care.

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8. APPENDIX

8.1. Declarations

8.1.1. Declaration of AI use

This dissertation used ChatGPT (OpenAI) and Claude (Anthropic) as language-support tools for translation, language review, and editing to improve clarity and flow. The intellectual work – including the development of the research questions, the theoretical framing, the study design, data collection, analysis, interpretation of findings, and all substantive arguments – was carried out by the author. Generative AI was not used to generate original empirical results, and the author takes full responsibility for the entire content of the dissertation.

8.1.2. Funding statement

The studies in [Chapters 3](#) and [4](#) were supported by the Momentum Programme of the Hungarian Academy of Sciences (Grant LENDULET_2021-78). The dissertation was also supported by the project “Transforming Anxieties of Ageing in Southeastern Europe: Political, Social, and Cultural Narratives of Demographic Change” funded by the Volkswagen Foundation. The MTA SYLFF (Sasakawa Young Leaders Fellowship Fund) scholarship contributed to the development of the theoretical and conceptual framework.

8.2. Expert interviews

This section includes the interview guide used during the conduct of expert interviews used in [Chapter 2](#). The original interview guide was developed in Hungarian and translated into English by the author for publication purposes.

8.2.1. Expert interview guide (English)

Expert interview guide

The planned expert interviews are structured around the following three blocks. The guide is tentative, and the interviewer may depart from it when necessary and may formulate additional follow-up questions.

1. The interviewee’s biography: mapping their professional career and motivations

- Please tell me about your professional career, and also explain how you first became involved in obstetrics and in issues and phenomena related to birth and childbirth.
- Please also tell me about your current main professional activity.

2. The expert’s general perspective on obstetric care

- How do you see the current situation of obstetric care in Hungary? What do you consider the biggest **a)** challenges and **b)** successes?
 - The relationship between public and private care
 - The issue of informal payments
 - The needs and experiences of women in different situations
 - The impact of COVID-19
- In your opinion, what factors determine women's satisfaction with childbirth?
- To what extent are these conditions met in Hungary?
- What **a)** challenges and **b)** good practices / approaches / alternatives do you see in Hungarian obstetric care?

3. Experts' views on changing care and the future

- How do you see the future of obstetric care, and what changes do you consider likely in the near future?
- What opportunities do you see for increasing satisfaction with childbirth?

I have reached the end of my questions. Is there anything that remains unsaid, something I may not have asked about, or something that occurred to you during the interview?

Thank you very much for your participation and for sharing your thoughts.

8.2.2. Expert interview guide (Hungarian)

Szakértői interjú vezérfonala

Az alábbi három blokk mentén strukturálódnak a tervezett szakértői interjúk. A vezérfonal vázlatos, amelytől a kérdező adott esetben eltérhet, illetve alkérdéseket fogalmazhat meg.

1. Az interjúalany biográfiája: a szakmai karrier és a motivációk feltérképezése

- Kérem, mesélje el a szakmai karrierjét, és térjen ki arra is, hogyan kezdett el a szülészettel, valamint a születéssel és szüléssel kapcsolatos kérdésekkel, jelenségekkel foglalkozni!
- Kérem, mesélje el a jelenlegi fő szakmai tevékenységét is!

2. A szakértő általános rálátása a szülészeti ellátásra

- Hogyan látja a hazai szülészeti ellátás helyzetét? Mik a legnagyobb **a)** kihívások, **b)** sikerek?
 - Az állami és a magánellátás viszonya
 - A hálapénz kérdése
 - A különböző helyzetű nők igényei és tapasztalatai
 - A COVID-19 hatása
- Ön szerint milyen tényezők határozzák meg a nők szüléssel való elégedettségét?
- Magyarországon ez mennyire teljesül?
- Milyen **a)** kihívásokat és **b)** jó gyakorlatokat / megközelítéseket / alternatívákat lát a magyar szülészeti ellátásban?

3. A szakértők álláspontja a változó ellátásról és a jövőről

- Hogyan látja a szülészeti ellátás jövőjét, milyen változásokat tart valószínűnek a közeljövőben?
- Mit gondol, milyen lehetőségek vannak a szüléssel való elégedettség növelésére?

Én a kérdéseim végére értem. Maradt-e Önben valami, amit esetleg nem kérdeztem, vagy ami az interjú során jutott eszébe?

Köszönöm szépen a részvételt, és hogy megosztotta gondolatait!

8.3. Survey materials

This section provides information about the survey dataset used in [Chapter 4](#).

The questionnaire was commissioned by the *Lendület Research Group on Reproductive Decisions*, funded by the Hungarian Academy of Sciences.

The aim of the research was to map opinions and attitudes related to childbearing in Hungarian society. Data were collected in April 2024 by Panelstory Public Opinion Research using a nationally representative sample of 1,500 respondents.

The questionnaire covers issues related to childbearing, pregnancy and childbirth, as well as attitudes toward abortion, contraception, and assisted reproduction.

The full questionnaire is available at the following link:

https://reprosoc.tk.elte.hu/uploads/files/Supplementary_file_1_survey.pdf

8.4. Mother interviews

This section presents the semi-structured interview guide used in [Chapter 5](#). The original interview guide was developed in Hungarian and translated into English by the author. The guide was used flexibly during interviews, allowing for follow-up questions and thematic elaboration.

8.4.1. Mother interview guide (English)

Introduction to the Study

This research focuses on childbirth experiences.

The interview will be processed anonymously. Sensitive topics may arise during the conversation, and these may affect individuals differently. If there is any question you prefer not to answer, you are not obliged to do so, and we can move on. If at any point during the interview you feel uncomfortable, we can take a break or discontinue the interview entirely.

If, during or after the interview, you feel that you need support, I recommend the following free professional service:

EMMA Vonal (EMMA Helpline)

+36-80-414-565

emmavonal@emmaegyesulet.hu

<https://emmaegyesulet.hu/emma-vonal/>

1. Life History

Please introduce yourself and tell me about your life story.

2. Thematic Questions*

**If not already discussed in Section 1.*

Family Background

- What kind of family do you come from? Could you tell me about your parents (e.g., parents, grandparents, their highest level of education, occupation, background, place of residence)? What kind of environment did you grow up in?
- Do you have siblings? Could you tell me about them (e.g., number of siblings, birth order, their education, occupation, place of residence)?
- What does family mean to you?

Educational Background

- Where did you attend school?
- Did you pursue further education? If yes, why did you choose that path? What was your main motivation?
- At any stage of your education, did you receive formal (e.g., school lessons) or informal (e.g., peers) information about childbearing or childbirth?

Career and Work

- What kind of work do you do / have you done, and where?
- What does your work mean to you?

Social Networks (Family, friends)

- What is your relationship like with your parents, siblings, and extended family (e.g., how often do you meet)?
- How many close friends do you have? What is your relationship like with them? How do you know them? How often do you meet?
- How has your relationship with them changed since having children?
- Was there a period in your life when you felt lonely or felt that you did not belong to any community?
- Are you a member of any other community that you regularly attend or identify with (e.g., religious, creative, mother–baby groups, etc.)?

Intimate Relationship

- What does an ideal partner mean to you?
- How many long-term relationships have you had previously?
- Had you previously considered having children?
- (If applicable) Please tell me about your current relationship / husband / the father of your child. When did you meet? What does he do? How did your relationship develop?

Childbearing

- When did you first think about having a child?
- Did you ever perceive pressure from friends, family, or your social environment regarding marriage or family formation?
- Did having a child ever cause doubts or uncertainty for you?

3. Childbirth

Before Childbirth

- How did you find out about your pregnancy?
- Was it a planned pregnancy? If yes, how did you prepare (e.g., taking vitamins, etc.)?
- Did you prepare for childbirth in any way?
- Which institutions or professionals did you visit?
- Did you provide any form of compensation (e.g., financial) in exchange for services, information, or support?

Please tell me how your childbirth took place.

Childbirth (Follow-up Questions)

- Where did you give birth? How did you give birth?
- Who was present during the birth?
- Was the father present?
- Could you tell me about the father's role around childbirth?
- Who could you rely on?
- How did you experience the birth?
- What kind of medical care did you receive?
- Were there any medical complications?
- Did you provide any form of compensation (e.g., financial) in exchange for services, information, or support?

After Childbirth

- When did you first see your baby?
- How long did you stay in the hospital? Were you in a private or shared room? What was your relationship like with the staff? Were you able to ask for help and did you receive it?
- What was your experience in the neonatal ward? Did you breastfeed?
- Did you provide any form of compensation (e.g., financial) in exchange for services, information, or support?
- How do you evaluate the preparation before childbirth?
- Did you experience any health problems after childbirth?
- What was the most negative experience during childbirth?
- What was the most positive experience during childbirth?

Socio-Political Context

- Do you receive any state family benefits (e.g., CSED, GYED)? Have you taken any family-related loans (e.g., baby loan, CSOK housing subsidy)?
- To what extent does this support you?

4. Future and Closing

- If you were to give birth again, would you do anything differently?
- Are you planning to have more children? Did you previously have different plans? If the number of children differs from your earlier plans, what are the reasons?
- What are your plans for the future?
- Is there anything you consider important regarding the topic of this research that I did not ask about but came to mind during the interview?

Thank you very much for participating in the research.

8.4.2. Mother interview guide (Hungarian)

Interjú vezérfonal

Kutatás ismertetése. Fókusz: szülésélmény.

Az interjú név nélküli módon kerül feldolgozásra. Az interjúban érzékeny témák kerülhetnek elő, amik mindenkire máshogy hathatnak. Ha van olyan kérdés, amire nem kívánsz válaszolni, nem kötelező, tovább lépünk. Az interjú során, ha bármikor kellemetlenül érzed magát, szünetet tarthatunk, vagy bármely pontján megszakíthatjuk az interjút. Ha a beszélgetés során, vagy utólagosan azt éreznéd, hogy segítségre van szükséged, ingyenes szakmai ajánlásom:

EMMA Vonal: +36-80-414-565

1. Élettörténet

Kérlek, mutakozz be és mesélj magadról, meséld el az élettörténetedet!

2. Tematikus kérdések*

Családi háttér

- Milyen családból származol? Mesélnél a szüleidről (pl. szülők, nagyszülők bemutatása, legmagasabb iskolai végzettségük, foglalkozásuk, származásuk, lakóhelyük)? Milyen környezetben nevelkedtél?
- Van testvéred? Mesélnél róluk (pl. testvérek száma, ő hányadik gyermek, iskolai végzettségük, foglalkozásuk, lakóhelyük)?
- Mit jelent számodra a család?

Iskolai pályafutás

- Hova jártál iskolába?
- Továbbtanultál? Ha igen, miért azt választottad? Mi volt a fő motivációd?
 - o Bármelyik iskolai szinten kaptál információt formális (pl. iskolai tanóra) vagy informális (pl. kortársak) úton a gyerekvállalással és a szüléssel kapcsolatban?

Karrier, munka

- Mit és hol dolgozol/dolgoztál?
 - o Mit jelent számodra a munkád?

Családi és baráti kapcsolatok

- Milyen a kapcsolatod a szüleiddel, testvéreiddel, tágabb rokonsággal (pl. milyen gyakran találkoztok)?
- Hány közeli barátod van? Milyen a kapcsolatod velük? Honnan ismered őket? Milyen gyakran találkoztok?
 - o Hogyan alakult a kapcsolatod velük a gyermekvállalás óta?
- Volt olyan életszakaszod, amikor magányosnak érezted magad, amikor úgy érezted, hogy semmilyen közösséghez nem tartozol?
- Van bármilyen másfajta közösség, ahova rendszeresen jársz vagy amelynek tagjának érzed magad (pl. vallási, kreatív, baba-mama klub stb.)?

Párkapcsolat

- Milyen az ideális társ/partner számodra?
- Életedben korábban hány tartós párkapcsolatod volt?
- Gondoltatok korábban gyermekvállalásra?
- (Ha van) Mesélj a jelenlegi párkapcsolatodról/férjedről/gyermeked apjáról! Mikor ismerted meg? Mivel foglalkozik? Hogyan alakult a kapcsolatotok?

Gyermekvállalás, családalapítás

- Mikor gondoltál először arra, hogy szeretnél gyereket?
- Érzékeltél bármilyen közegben, barátok, család részéről nyomást korábban, hogy házasság, család?
- A gyerekvállalás okozott bármikor kételkedést benned?

3. Szülés

Szülés előtt

- Hogyan tudta meg a terhességét?
- Kívánta a terhességét? Ha igen, hogyan készítette fel magát a terhességre (pl. szedte a vitaminokat stb.)?
- Készült valahogyan a szülésre?
- Milyen intézményeket, szakembereket látogatott?
- A szolgáltatásért, információért, támogatásért cserébe nyújtotta bármilyen viszonzást (pl. anyagi)?

Kérlek, meséld el, hogyan zajlott a szülésed!

Szülés (visszakérdező blokk)

- Hol szültél?
- Kik voltak bent a szülés ideje alatt? Apas szülés volt?
- Mesélnél kicsit az apa szerepéről a szülés körül!
- Kikre tudta támaszkodni?
- Hogyan élted meg a szülést?
- Milyen orvosi ellátásban részesültél?
- Volt bármilyen orvosi komplikáció?
- A szolgáltatásért, információért, támogatásért cserébe nyújtotta bármilyen viszonzást (pl. anyagi)?

Szülés után

- Mikor láttad a gyermekedet először?
- Meddig voltál a kórházban? Egyéni vagy csoportos kórteremben voltál? Milyen volt a viszonyod az intézményben dolgozókkal? Tudta segítséget kérni és kapta tőlük?
- Milyen volt a csecsemőosztályon? Szoptattál?
- Bármilyen szolgáltatásért, információért, támogatásért nyújtotta bármilyen viszonzást (pl. anyagi)?
- Hogyan értékeled a szülést megelőző felkészülést?
- Előfordult veled a szülést követően bármilyen egészségi probléma?
- Mi volt a legnegatívabb élményed a szülés során?
- Mi volt a legpozitívabb élményed a szülés során?

Társadalmi-politikai kontextus

- Ti részesültök bármilyen állami családtámogatásban (pl. CSED, GYED) ? Vettetek fel bármilyen családtámogatási hitelt (pl. babaváró, CSOK)?
- Mennyiben segít ez neked?

4. Jövő, lezárás

- Ha újra szülnél, csinálnál bármit másképp, változtatnál bármin?
- Tervezel még gyereket? Korábban máshogy terveztél? Ha kevesebb/több a gyerekszám a tervezettnél: mi az oka, hogy kevesebb/több gyereket szeretnél?
- Mik a terveid a jövőt illetően?
- Van bármi, ami szerinted fontos lenne a kutatás témáját illetően, de én nem kérdeztem meg, és eszedbe jutott interjú közben?

Köszönöm szépen az interjút!

8.4.3. Mother interview consent form

Tájékoztató és hozzájárulási nyilatkozat kutatási részvételhez

Kedves Résztvevő!

Köszönöm, hogy részt vesz kutatásomban. A Budapesti Corvinus Egyetem Szociológia Doktori Programjának keretében zajló *Szülésnarratívák a magyar szülészeti ellátásban* (Women's Birth Narratives in the Hungarian Obstetric Care; KRH/111/2024) című doktori kutatás célja, hogy összehasonlító elemzést készítsen magyar állami intézményben szült nők szülésélményeiből.

A kutatás során interjúra kerül sor, amelyről hangfelvétel készül. A rögzített felvételtől anonimizált, név nélküli leírat készül.

A kutatás során érzékeny témák merülhetnek fel, amelyek mindenkire másképp hathatnak. Az interjú során, ha bármikor kellemetlenül érzi magát, szünetet tarthat, vagy bármely pontján megszakíthatja az interjút. Ha a beszélgetés során, vagy utólagosan azt érezné, hogy segítségre van szüksége, ajánlást tudok adni ingyenes, szakmai szolgálathoz. Kérem, keressen levélben vagy telefonon.

A részvétele önkéntes. Bármikor kiléphet a kutatásból, s kérheti adatainak törlését, vagy megtudhatja, hogy milyen adatokat tárolok Önről. Írjon nekem vagy hívjon fel.

Semmilyen azonosítható személyes adatot nem fogok Önről nyilvánosságra hozni. A név nélküli adatokkal elsősorban a kutatásban részt vevő kutató dolgozik. A kutatásból magyar és angol nyelvű tudományos írások fognak születni.

Köszönöm, hogy segíti kutatásomat!

A kutatás készítője: Udvari Orsolya

A kutatás intézménye: Budapesti Corvinus Egyetem, Szociológia és Kommunikációtudomány Doktori Iskola, Szociológia Doktori Program

Hozzájárulási nyilatkozat

Eloolvastam vagy felolvastattam és megértettem ezt a kutatásról szóló tájékoztatót és beleegyezem az adataim kezelésébe. Volt módom arra, hogy kérdéseket tegyek fel a kutatásról és a kérdésekre kielégítő választ kaptam.

Önkéntesen veszek részt ebben a kutatásban és megértettem, hogy megtagadhatom a válaszadást és bármikor indoklás nélkül kiléphetek a kutatásból.

Beleegyezem abba, hogy az általam adott információkat lehet idézni kutatási beszámolómban.

Aláírás

Résztvevő neve

Aláírás

Dátum

Ha a résztvevő nem tud aláírni, ikszeljen ide.

Pontosan felolvastam a tájékoztatót a potenciális résztvevőnek és a legjobb képességeim szerint biztosítottam, hogy megértse a résztvevő, mihez járul hozzá önkéntesen.

Kutató neve

Aláírás

Dátum

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