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Thesis summary

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**Childbirth in Hungarian Obstetric Care:
Attitudes, Experiences, Inequalities**

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Introduction

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), and they are particularly pronounced in Europe (Makay and Ökrös, 2024). The process of population change is usually surrounded by a public discourse of panic and anxiety, often articulated through narratives about national decline. Yet these demographic anxieties are predominantly centred on fertility and reproductive issues rather than on other major dimensions such as ageing and care (Melegh, 2026). When the “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, as does the social organisation of care, despite its centrality to long-term social reproduction.

This article-based dissertation starts from 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. Welfare-state responses to demographic change are frequently organised through social policy, which often places a strong emphasis on fertility and birth rates. Pronatalist family policies aimed at encouraging childbearing are especially prominent in the Hungarian case (Fodor, 2022; Szikra, 2018a, 2018b; Szikra and

Autischer, 2025). In Hungary, pronatalism forms part of a broader normative framing of demographic responsibility and of what legitimate and socially valued family life should look like.

This 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 merely a rhetorical question; it points to a structural contradiction in contexts where childbirth becomes a politically significant event while the organisation of care does not necessarily reflect this significance.

To conceptualise these processes, the dissertation draws on the concept of reproductive governance, which refers to the mechanisms through which diverse configurations of actors use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices (Morgan and Roberts, 2012). Crucially, governance operates through stratification; these processes must therefore be examined through an intersectional perspective (Crenshaw, 1989; Csányi and Kováts, 2020), with particular attention in this dissertation to socio-economic position, education, place of

residence, and the racialisation of Roma women (Wacquant, 2022). These positions shape not only formal access to care, but also women's exposure to institutions, recognition within care encounters, and their room for manoeuvre.

The focus is on experiences, satisfaction, attitudes, and access, and on how social positions shape both exposure to care and the room for manoeuvre available within institutions. Empirically, childbirth is treated 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 operate not only through differential access to services or clinical resources, but also through patterned differences in recognition, communication, continuity, and control. They are further reflected in the unequal – and often invisible – work women must undertake to make care pathways workable (Bradby *et al.*, 2019), including the mobilisation of money, information, social relations, or (partial) exit from the public system.

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 dissertation moves from an international mapping of existing evidence, through population-level

patterns in Hungary, to an in-depth qualitative examination of women's experiences and strategies of navigation in obstetric care.

I. Research background and relevance

The conceptual backbone of the dissertation is the framework of reproductive governance developed by Morgan and Roberts (2012), which serves as an analytic tool for tracing the shifting political rationalities of population and reproduction. The framework is theoretically grounded in Michel Foucault's concept of biopower: modern states govern by managing and disciplining the physical–biological life of their population, linking the regulation of individual bodies to the broader management of populations (Foucault, 1991, 2008; Morgan and Roberts, 2012). Building on Foucault's "regimes of truth," reproductive governance also draws attention to moral regimes that categorise reproductive actions as rational or irrational and set the stage for what has been termed stratified reproduction; the different worthiness that society assigns to women and their reproductive processes (Castro and Savage, 2019). It further highlights how political-economic processes, including the privatisation of healthcare, can transform citizens into consumers of reproductive services under the language of individual choice (Morgan and Roberts, 2012).

Reproductive governance is not only enacted from the top down; it is experienced in situated ways. To capture how women act

within a governed and stratified system, the dissertation employs the concept of healthcare bricolage, which describes the situated work through which individuals assemble formal and informal services, knowledge, social relations, and other available resources into workable care pathways (Phillimore *et al.*, 2015, 2018, 2019a). In this dissertation, bricolage is interpreted primarily as a response to institutional fragmentation and uncertainty rather than simply as an expression of individual resourcefulness or consumer choice. This does not imply that structural constraint, personal agency, and consumer orientations are mutually exclusive; rather, the analytical question is under what institutional conditions, with which resources, and at what cost women are required to exercise agency.

The third analytical pillar is intersectionality, which directs attention to the fact that governing arrangements do not position or affect all women in the same way (Crenshaw, 1989). The dissertation focuses particularly on socio-economic position, education, place of residence, and the racialisation of Roma women, examining how these shape exposure to obstetric institutions, access to resources, and recognition within care encounters. Intersectionality therefore makes it possible to analyse not only unequal access to resources, but also unequal returns from apparently similar resources: money, knowledge, or preparation may have different consequences depending on how a woman is positioned and perceived within an institution.

Taken together, the three analytical approaches capture a movement from governing arrangements, through differentiated institutional positions, to everyday navigation. Reproductive governance identifies the formal rules, market opportunities, professional hierarchies, and moral classifications within which childbirth takes place; intersectionality explains how exposure to these conditions and the capacity to respond to them are socially differentiated; and healthcare bricolage captures the practical work through which women attempt to make care pathways workable.

Hungary is a particularly relevant case. Since 2010, successive governments have considerably intensified Hungary's pronatalist family-policy orientation, in which access to resources and recognition is socially selective and particular family forms and reproductive behaviours are privileged over others (Fodor, 2022; Szikra, 2018b). At the same time, Hungary has an increasingly hybrid healthcare system in which publicly funded provision coexists with a growing private sector, and access to faster, more predictable, or more individualised care is partly structured by financial resources (Veroszta and Szabó, 2021). Obstetric care specifically, but not exclusively, was historically marked by informal or "gratitude" payments, closely connected to the chosen-obstetrician model through which women sought continuity, predictability, and trust within public care (Baji *et al.*, 2017; Udvari and Szalma, 2025).

A major institutional turning point came with the 2021 healthcare reform, which criminalised informal payments and restructured health workers' employment conditions (Gaal *et al.*, 2021). In obstetric care, these changes reshaped established arrangements for continuity: the previously common mechanism of a chosen doctor largely disappeared, and care became more dependent on which professionals happened to be on duty at the time of birth. The reform did not, however, automatically resolve the fragmentation or inequalities of the system. Together with the continued expansion of private provision, these changes make the Hungarian case particularly useful for examining how women attempt to secure continuity, information, predictability, and dignity when these conditions are not institutionally guaranteed.

International research demonstrates that childbirth experiences are socially patterned. Studies focusing specifically on negative childbirth experiences commonly report rates of approximately 8–12% (Baas *et al.*, 2017; Viirman *et al.*, 2022; Vedeler *et al.*, 2023), while a broader literature identifies socio-economic position, education, ethnicity, and other dimensions of social position as relevant to experiences of childbirth and obstetric care (Daoud *et al.*, 2015; Tian *et al.*, 2018; Vedeler *et al.*, 2023).

In Hungary, research similarly documents socially differentiated access to obstetric care and racialised forms of classification and mistreatment affecting Roma women (Szabó and

Veroszta, 2022, 2024; Balogh, 2025; Balogh-Szabó, 2023). These inequalities concern not only access to services or clinical outcomes, but also information, communication, recognition, and women's room for manoeuvre within institutions.

Against this background, the dissertation examines inequality at three complementary levels. The first study maps recurring international patterns and gaps in knowledge; the second identifies population-level patterns of satisfaction and perceived access to better obstetric care in Hungary; and the third examines the mechanisms and strategies through which unequal and uncertain care is anticipated and navigated in women's experiences.

II. Data and methods

The three empirical studies (Chapter 3–5) differ in scope, methodological approach, and analytical focus, moving from a broad international evidence base to the specific dynamics of Hungarian obstetric care. They provide complementary forms of evidence rather than constituting sequential components of a conventional mixed-methods design. While all three address the relationship between socio-economic position and experiences around childbirth, they operationalise and examine it in different ways. In addition, seven expert interviews conducted in 2025 with professionals and civil-society actors connected to obstetric care provide contextual material for the dissertation. They are used for contextualisation and

triangulation of system-level processes rather than treated as a separate empirical study.

Chapter 3. A Scoping Review on the Relationship Between Maternal Experiences Around Childbirth and Socio-economic Factors in OECD Countries

The first study is a scoping review mapping the international literature on the relationship between maternal experiences around childbirth and socio-economic factors in OECD countries. The review deliberately covers the prenatal period, childbirth itself, and the postnatal period. A predefined keyword search was conducted in three databases (Scopus, Web of Science, and PubMed) in the titles and abstracts of English-language journal articles published between 2013 and 2024, combining terms for perinatal experiences (e.g. childbirth, childbearing, maternal, and pregnancy experiences) with terms for socio-economic position (e.g. socio-economic status, social class, economic status, social status). The database search identified 103 results; after abstract screening 64 remained, reduced to 44 after removing duplicates, and to 16 after applying the geographical-scope criterion, with a further two articles added through reference tracing, giving a final corpus of 18 studies. The reporting followed the PRISMA framework (Moher *et al.*, 2009). Among the included studies, quantitative analyses were in the majority ($n = 10$), followed by qualitative ($n = 6$) and mixed-methods studies ($n = 2$).

Chapter 4. Socio-demographic Factors, Informal Payments and Satisfaction with Childbirth in the Hungarian Context

The second study is quantitative and turns to the Hungarian context, examining how socio-demographic factors relate to satisfaction with childbirth, with particular attention to the historically embedded role of informal payments. It draws on a cross-sectional survey conducted between February and April 2024 on a sample of 1,506 individuals, nationally representative by age, gender, and type of settlement, with representativeness ensured through post-stratification weighting based on 2022 Census data. Data were collected through a hybrid method (66.9% online, 33.1% in person). Perceptions of unequal access were captured through seven items asking who receives better obstetric services (for example, those in a better financial situation, those with adequate knowledge of hospital procedures, those who give informal payments, or those with a privately hired obstetrician), rated on a four-point scale. These questions were asked of the broader adult sample, including respondents without childbirth-related experience.

Satisfaction with childbirth was measured with a single, deliberately gender-neutral item, allowing both mothers and fathers evaluating their partners' obstetric care to be included. Independent variables included gender, education, financial status, the father's presence in the delivery room, and the year of childbirth. Analyses were conducted in Stata 18: chi-square tests, factor analysis of the perception items

(KMO = 0.869), and binary logistic regression of birth satisfaction. The regression analysis was restricted to respondents with relevant childbirth-related experience and complete data (N = 695).

Chapter 5. Making Do, Unequally: Reproductive Governance, Bricolage and Racialised Access to Childbirth Care in Hungary

The third study is qualitative and examines how women construct and navigate care pathways in the institutional context reconfigured following the 2021 criminalisation of informal payments and related regulatory changes. The analysis draws on 26 in-depth, semi-structured interviews with Roma (n = 13) and non-Roma (n = 13) mothers from diverse social backgrounds, including women from both lower and higher educational groups. Interviews were conducted between 2022 and early 2026, with most carried out in 2024; the earliest interviews also contributed to refining the interview guide and sharpening its focus on childbirth experiences. Participants were women aged 22–44 from four main types of location: the capital (n = 7), its agglomeration (n = 7), other cities (n = 7), and one disadvantaged village in Northern Hungary (n = 5). Most interviews were conducted face-to-face (n = 18), while eight were conducted online. The setting varied between conventional one-to-one interviews and interviews in shared domestic spaces. The analysis followed an abductive approach, moving iteratively between the empirical material and theoretical concepts (Timmermans and Tavory, 2012; Thompson,

2022). Interview transcripts were coded in MAXQDA through multiple rounds of revisiting and refining categories. Phillimore *et al.*'s healthcare-bricolage typology (2019b) was used as an interpretative framework.

III. Results

The findings are presented study by study and then drawn together. Across the three studies, socio-economic and socio-demographic position emerges as a consistent structuring force behind experiences, satisfaction, and the strategies women adopt around childbirth. Read together, the studies move from identifying recurring international patterns of inequality to examining their population-level manifestations and mechanisms in the Hungarian context.

Chapter 3

- Studies focusing on childbirth experiences reported negative experiences in approximately 8–12% of cases. Across the full corpus of 18 studies, socio-economic factors were associated with perinatal experiences and outcomes, although the direction and strength of these associations varied across specific dimensions and contexts.
- In the prenatal period, maternal socio-economic and mental-health history, as well as inequalities in access to and treatment within antenatal care, were associated with experiences and outcomes.

- Studies of childbirth identified both risk and protective factors for negative experiences; qualitative evidence additionally highlighted the importance of health insurance and perceived control.
- Postnatal studies linked socio-economic disadvantage to postpartum depression and post-traumatic stress, alongside traumatic birth experiences and obstetric complications.
- Overall, the review shows consistent socio-economic patterning but a predominantly quantitative and geographically uneven evidence base, with limited attention to women's narratives and the mechanisms producing inequalities.

Chapter 4

- Despite the criminalisation of informal payments in 2021, financial factors remained prominent in perceptions of access to better obstetric care. Around 77% of respondents associated having a private obstetrician, 72% informal payments, and 68% better financial circumstances with better care.
- Factor analysis identified two dimensions – financial and competence – explaining 42.3% and 16.8% of the variance, respectively.
- Overall, 10.8% of respondents with childbirth-related experience were dissatisfied with obstetric care.

Dissatisfaction was higher among women (13.8%) than among fathers (6.1%).

- The logistic regression showed significantly lower odds of satisfaction among women compared with men (OR = 0.47), respondents with higher compared with lower education (OR = 0.40), and those struggling financially compared with those making ends meet (OR = 0.49).
- Respondents whose childbirth occurred after 2020 had substantially lower odds of satisfaction than those whose experience preceded 1990 (OR = 0.22). Higher scores on the competency factor were associated with higher odds of satisfaction (OR = 1.54), whereas higher scores on the financial factor were associated with lower odds of satisfaction (OR = 0.74).
- The findings demonstrate clear socio-demographic patterning in satisfaction and in perceptions of the factors associated with access to better obstetric care.

Chapter 5

- Bricolage primarily operated as anticipatory risk management aimed at securing predictability, continuity, safety, and respectful treatment under conditions of institutional uncertainty.

- Three literature-informed forms were identified: added-to-system, within-system, and alternative bricolage.
- The post-2021 institutional context reconfigured previously available mechanisms of continuity: the earlier informal mechanism of a chosen obstetrician weakened, while women described hybrid arrangements – most visibly private antenatal care combined with public birth – as ways of securing greater predictability and continuity.
- Access to bricolage was socially stratified. Resource-intensive strategies were more available to women able to mobilise money, knowledge, and social relations, while others relied more heavily on within-system strategies.
- Resources also produced unequal returns. Money could buy access, comfort, information, and partial continuity, but did not reliably protect Roma women from racialised judgement, disbelief, or disrespect.
- The findings extend healthcare bricolage to childbirth in a formally universal healthcare system and conceptualise it as structurally produced patient work, while highlighting its ambiguous relationship with reproductive governance.

Overall conclusions

Taken together, the three studies show that socio-economic inequalities shape childbirth not only through differential access to

services and patterned experiences of care, but also through the unequal work required to secure predictability, continuity, recognition, and dignity. Viewed through reproductive governance, these findings reveal a tension between selective pronatalism and an obstetric-care environment that does not consistently provide respectful, predictable, and equitable care.

Empirically, the dissertation connects international evidence, population-level patterns in Hungary, and qualitative accounts of women's navigation of obstetric care. It shows that inequalities extend beyond access and experiences to the work required to make care pathways workable.

Conceptually, the dissertation extends healthcare bricolage to childbirth within a formally universal healthcare system. Childbirth-related bricolage emerges as anticipatory, structurally produced patient work that can provide partial control while also shifting responsibility for institutional shortcomings onto women and their families.

The dissertation brings reproductive governance, intersectionality, and healthcare bricolage into a common analytical framework: reproductive governance identifies the institutional and moral terrain, intersectionality explains women's differentiated positions within it, and bricolage captures their everyday navigation. This integration highlights not only unequal access to resources, but also unequal returns from similar resources.

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V. The author's publications on the topic

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Conference presentations

Udvari, O. (2024) 'Women's birth narratives in Hungarian obstetric care: Introduction to a qualitative study', paper presented at *Thinking Through Motherhood: Images, Experiences and Narratives Across Time*, Vilnius, Lithuania, 23–25 January.

Udvari, O. (2024) 'Women's birth narratives in Hungarian obstetric care: Application of a preliminary thematic coding system in the analysis of in-depth interviews on birth experiences', paper presented at the *Sixth Joint Doctoral Conference*, University of Trento, Trento, Italy, 28–29 November.

Udvari, O. and Szalma, I. (2025) 'Satisfaction with childbirth: Socio-demographic factors and informal payments', paper presented at the *Young Demographers Conference*, Charles University, Prague, Czech Republic, 5–7 February.

Manuscript under review

Udvari, O., Szalma, I. and Durst, J. (2026) 'Does money really talk? Bricolage in the context of racialised and classed access to childbirth care in Hungary'. Manuscript submitted to *Sociology of Health & Illness*, under review.

A complete and up-to-date list of the author's publications is available in the Hungarian Scientific Bibliography (MTMT): [MTMT author profile](#)