

Improving the Birth Experience in Low- and Middle-Income Countries: An Interdisciplinary Note

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Abstract

The quality of maternal healthcare depends not only on access to effective and safe care, but also on women's experiences of care, including whether they are able to participate in decisions concerning their care, and whether their needs and preferences are respected. In low- and middle-income countries (LMICs), women's birth experiences remain marked by social and contextual inequalities, while approaches to person-centred and respectful maternity care remain unevenly implemented and institutionalised.

Within this broader framework, the thesis focuses on women's birth experience across heterogeneous LMIC settings, and investigates how aspects of maternity care relate to women's preferences and reported experiences. First, within the QUALI-DEC project, implemented in Argentina, Burkina Faso, Thailand and Viet Nam, the thesis investigates whether correspondence between women's preferred mode of birth in late pregnancy and the mode of birth documented in their medical records is relevant to their reported birth experience. Birth experience was assessed using Birth Experience Scores (BES). It also seeks to identify which configurations of labour companionship are associated with higher BES and could therefore inform practical, context-specific recommendations for implementing labour companionship. Second, within a maternal-health research project in Madagascar, a more resource-constrained context, the thesis provides context-specific evidence on women's expectations and experiences, and on potential areas for improvement identified from the perspectives of women and healthcare providers.

This interdisciplinary note situates the efforts that could build on and complement the thesis findings within the broader health-system, social, organisational and policy conditions needed to improve women's birth experience. It highlights the diversity of actors involved and the need to consider their unequal power and capacities to influence policy and implementation when seeking to improve women's birth experiences. Moreover, perspectives from the sociology of public action, including street-level bureaucracy and locally driven 'reform from below', can help anticipate how research recommendations may be interpreted, negotiated and adapted when translated into practice. In addition, while the thesis focuses primarily on downstream factors within maternity care and can help identify what matters to women and healthcare providers, it does not address the social and cultural determinants that shape birth experiences. Health promotion therefore offers one potential strategic avenue for addressing levers upstream of clinical care, although these are more complex to implement than the approaches directly explored in the thesis. Finally, improving birth experience and the implementation of a person-centred maternity care also raise questions about how interventions can be sustainably financed and embedded within routine health-system structures beyond externally supported programmes.

Background and rationale

Why women's birth experiences matter for public health

Poor-quality care is estimated to contribute to 5.7 – 8.4 million deaths annually in LMICs, representing up to 15% of all deaths in these settings (1). For maternal and newborn care, the World Health Organization (WHO) defines two interlinked dimensions of quality: the provision of care and the experience of care. The experience of care includes effective communication, respect and preservation of dignity, and emotional support (2,3).

Over recent decades, efforts to improve maternal health have appropriately focused on the provision of care, increasing access to skilled care, strengthening health-system capacity and ensuring the availability of essential interventions. However, negative experiences of care may undermine confidence in formal health services and discourage future use of these services (4). Traumatic birth experiences have been associated with psychological distress, including childbirth-related post-traumatic stress symptoms, and may affect women's subsequent engagement with formal health services (4,5). Disrespectful and abusive care have also been associated with lower utilisation of postnatal care (6), illustrating how the birth experience may affect both women's well-being and continued engagement with health services beyond the immediate postpartum period.

The birth experience is therefore a key quality of care outcome, reflecting whether women receive care that is respectful, responsive to their needs and preferences, and supportive of their participation and well-being (7,8).

Childbirth experience as a quality and equity concern

Within this broader quality-of-care framework, recent WHO guidance emphasises that respectful maternal and newborn care should be embedded within health-system policies and implementation strategies. Accordingly, person-centred care places women's birth experiences, preferences, values and participation at the centre of healthcare provision (7–9). Yet, these aspects of care remain insufficiently addressed in many maternity settings. Women may experience inadequate communication, limited involvement in decisions, insufficient support, stigma and discrimination, or physical and verbal abuse during childbirth. Evidence from LMICs indicates important gaps in person-centred maternity care, particularly in communication and autonomy, with experiences varying across socioeconomic and healthcare contexts (2,10). In a WHO multicountry study, more than one-third of women experienced mistreatment during facility-based childbirth, with younger and less-educated women at greater risk (10). Other evidence from LMICs similarly shows that poorer and less-educated women report lower levels of person-centred care and greater exposure to mistreatment (11,12). These disparities suggest that women's birth experiences vary

according to socioeconomic and demographic characteristics, making birth experience an issue of both quality and health equity.

Positioning the thesis within the quality-of-care agenda

Against this background, improving women's birth experience represents an important but insufficiently explored aspect of efforts to improve the quality and equity of maternal healthcare in LMICs. The question asked in this thesis is how maternal healthcare can be made not only clinically effective and safe, but also responsive to women's needs, preferences and experiences.

The first part of the thesis contributes to this question by analysing two factors potentially associated with women's birth experience and relevant to person-centred maternity care: (i) the correspondence between women's preferred mode of birth and the mode of birth documented in medical records; and (ii) configurations of labour companionship, including its timing, the identity of the companion and whether the woman chose her companion herself (7,13,14). Using pooled data from baseline and endline cross-sectional surveys conducted within the QUALI-DEC project (15), women's birth experience was assessed using a validated questionnaire, and Birth Experience Scores (BES) were computed as the outcome of interest (16). The mode-of-birth analysis explores whether correspondence between women's preferences and documented care is associated with birth experience (4), while the labour-companionship analysis seeks to identify configurations associated with higher BES that may inform context-specific implementation (13).

The second part of the thesis extends this public-health question to a setting where the maternal health burden remains substantially higher. Through mixed-method formative research in Madagascar, it explores what women and healthcare providers identify as important for improving women's birth experience and the conditions in which such improvements could be considered within public healthcare facilities. These findings will inform the co-development and subsequent testing of a contextually appropriate intervention to improve birth experience in collaboration with stakeholders.

The thesis does not determine how recommendations should be financed, governed or implemented at scale; rather, it makes women's experiences measurable and provides evidence that can contribute to understanding relevant maternity care quality improvement efforts. Nonetheless, this interdisciplinary note situates these empirical investigations within a broader public health framework, drawing on epidemiology, social sciences, health promotion, health economics, public policy and quality-of-care approaches. It identifies relevant actors, programmes and financing mechanisms, and considers the operational challenges and opportunities involved in improving women's birth experience in LMICs.

From research to action: partnerships, implementation, multisectoral approaches and sustainability

Research partnerships within health-system programmes

The projects embedding the thesis illustrate how research, international partnerships and health-system actors can be brought together around quality-improvement goals.

The QUALI-DEC project was implemented in Argentina, Burkina Faso, Thailand and Viet Nam, where caesarean section (CS) rates have increased over recent decades. Thirty-two hospitals – eight per country – were selected based on local recognition of increasing CS rates and engagement in addressing this trend. Improving women's birth experience was a secondary outcome of the project (15). The quality-improvement interventions combined multiple components at facility level, with implementation processes, resources and contextual adaptations systematically documented to facilitate replication and potential scale-up (15). The project also brought together clinical experts, health-system actors and other local stakeholders around a shared quality-improvement agenda, illustrating how international research partnerships can support both evidence generation and contextually adapted implementation.

A different configuration is illustrated by the Ezaka Ho Tomady programme in Madagascar. Funded by the European Union, it provides technical assistance to the Ministry of Public Health. Its activities include research-action activities led by the Institut de Recherche pour le Développement to inform interventions implemented by technical and financial partners, mainly UNICEF Madagascar and the Centrale d'Achats de Médicaments Essentiels et Matériel Médical de Madagascar. The programme seeks to strengthen the health system, and the thesis research explores how improving women's birth experience could complement ongoing efforts to strengthen maternal healthcare. The research team has identified the improvement of birth experience as a potential area for intervention and will co-develop and test a strategy to improve BES in collaboration with programme and national stakeholders. The programme has therefore provided a platform for bringing this research direction into dialogue with health-system priorities, while the research itself defines and investigates the specific question of how women's birth experience could be improved. Research is co-constructed with national stakeholders and subsequently validated through collective processes, including a national workshop held in February 2025. This provides an example of knowledge brokerage in which research is not simply transferred to decision-makers, but developed and adapted through interaction between actors with different forms of expertise and responsibilities.

Implementation: power dynamics and frontline capacity for change

On the one hand, improving women's birth experience requires action at several levels of the health system and engagement from a range of actors, including public

authorities, health-facility managers, health professionals, women and their families, community and professional organisations, research institutions, and technical and financial partners. However, these actors do not have equal influence over how priorities are defined or implemented. A sociological perspective on public health action therefore draws attention to their different forms of power, interests and capacity to influence decisions, allocate resources and shape implementation. While some actors hold formal authority, others influence policy through professional expertise, legitimacy, funding or advocacy. Women and communities may have direct knowledge of the quality of care while having comparatively limited influence over institutional decisions (17,18). This points to the importance of strengthening social accountability in the provision of care, once evidence from the thesis and subsequent proof-of-concept testing is available, particularly as interventions are considered for implementation at larger scale. Civil society organisations and communities could then participate in developing and monitoring health-system dashboards that include indicators of how care is provided, by whom, and how women experience and assess that care.

On the other hand, the concept of street-level bureaucracy adds an important dimension to this analysis. Frontline health professionals do not simply implement policies as prescribed: they exercise discretion in interpreting and adapting policy requirements to professional values, institutional constraints and the realities of everyday practice. A qualitative study of community public health nurses, for example, showed how frontline workers negotiated the demands of policy and practice and used discretion to reconcile a new policy vision with local implementation constraints (19). Recent work on health-system change similarly highlights the role of frontline workers in adapting ways of working and taking ownership of improvements, while research on locally driven reform emphasises how local actors can develop solutions to everyday health-system problems and contribute to bottom-up change (20,21). These perspectives suggest that implementation is not a linear process in which policies are simply transferred from higher levels of the system to frontline practice. Future research should therefore identify which actors at lower levels of the health system have the capacity and legitimacy to initiate, negotiate and sustain changes in practice, and under what conditions they can do so. The thesis can provide evidence on what matters to women and healthcare providers, but translating this evidence into practice requires understanding who can act on it, how changes are negotiated and adapted locally, and what enables them to be sustained.

Multisectoral approaches

The thesis contributes to identifying downstream factors within health facilities that could be targeted by strategies to improve women's birth experience. Sociodemographic characteristics, community contexts, cultural norms and representations of childbirth, and family relationships may also constitute contextual factors or mechanisms through which expectations, healthcare-seeking and birth

experiences are formed (22,23). This limitation points to the need to consider health-promotion approaches alongside facility-level strategies when seeking to improve women's birth experience. Thus, beyond measuring women's preferences and identifying facility-level improvement efforts, health promotion offers one strategic avenue that may contribute to reducing inequalities in women's birth experiences. Multisectoral, multi-component interventions that combine provider-, health-system- and community-level actions may offer greater potential than single-level approaches (24). For example, interventions could combine community-based health education and women's groups with efforts to strengthen women's knowledge of their rights and available maternity-care options, while working with community organisations, education and social-service sectors to address barriers affecting younger and less-educated women. Such approaches have demonstrated potential to improve maternal and newborn health outcomes in low-resource settings (25,26). Nevertheless, they require adaptation to local norms, gender relations and cultural representations of childbirth (27), thereby calling for further sociological research-action to understand these processes and identify context-specific interventions. In addition, they require appropriate actors and participatory approaches, as well as the development and evaluation of and sufficient resources and financing for implementation and sustainability (22,25). Moreover, longer implementation timelines may affect their feasibility and attractiveness to health-system actors (23,25), highlighting the need for supportive policies, sustained financing and commitment at international, national and local levels.

Beyond project cycles: sustaining partnerships and knowledge production

Translating multi-level approaches into sustained improvements raises important operational challenges. Interventions that are technically feasible and potentially improving birth experiences may require substantial additional resources for training, supervision, data collection, infrastructure and equipment (15). In Madagascar, for instance, the health sector remains reliant on external financing, while recent declines in development assistance raise concerns about the sustainability of externally supported initiatives – such as birth experience improvement – and their integration into national health-system priorities (28). Beyond this thesis, long-term institutionalisation therefore depends not only on evidence, but also on funding, national ownership, coordination between actors and the capacity of health systems to integrate new approaches into routine services (29).

Now that the QUALI-DEC project has ended, analysis and further use of its data continue, but maintaining engagement with local actors across the four countries without project funding presents a further challenge. Findings and recommendations, such as those concerning labour companionship, may require further discussion with local actors, contextual retesting and evaluation before wider implementation. This highlights a broader challenge of sustaining research partnerships beyond time-limited

projects, for which it has been argued that funding should support “partnerships rather than projects” (30).

Finally, there is a need to align evidence with national priorities. The Madagascar experience further illustrates the complexity of aligning evidence with national priorities. Although birth experience was recognised by national stakeholders and considered worthy of investment through Ezaka ho Tomady funds, the Ministry of Public Health remains primarily focused on reducing maternal mortality. In a context of constrained resources, investments in birth-experience improvement must therefore be justified in terms of opportunity costs and their potential contribution to the Ministry’s core mandate. Demonstrating the effectiveness of the strategy developed in this thesis on birth experience is a first step; showing that improved birth experience leads to increased utilisation of public health facilities by women – beyond the proof-of-concept provided here – is essential. Ultimately, evidence that increased birth experience increases healthcare utilisation, and that this contributes to reductions in maternal mortality would be required to position birth-experience interventions within national priorities. This underscores a broader and ongoing challenge: ensuring that knowledge production meaningfully informs policy decisions and continues to illuminate the Ministry’s pathway toward sustainable improvements in maternal health.

Conclusion

Improving women’s birth experience requires both evidence on what women experience and attention to the conditions under which health systems can respond to those experiences. The discussion in this note highlights what lies beyond this empirical contribution. It shows that translating evidence into sustained improvements involves multiple actors and levels. It also requires attention to how policies are interpreted and adapted in practice, to the social and cultural conditions shaping women’s experiences, and to the resources, institutional arrangements and governance needed to sustain change. As illustrated by the experiences of QUALI-DEC and Ezaka Ho Tomady, the time required for research, partnership-building, implementation, adaptation and institutionalisation may extend beyond the timeframe of individual project cycles. This raises a practical question for health-system research: how can project-based research retain the responsiveness and accountability required to address an identified problem while allowing sufficient time for evidence to contribute to sustained change? Addressing this tension requires forms of scientific support that extend beyond the production of evidence and help make knowledge actionable and durable.

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