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Conditions in Maternity Wards and Childbirth Experiences in Serbia, Bosnia and Herzegovina, Montenegro, and Croatia

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Abstract

Various factors, including individual, interpersonal, and unexpected medical issues, play significant roles in shaping women's childbirth experiences. In response to the scarcity of research in this domain across the Balkan countries, this study offers foundational insights into the conditions prevalent in maternity wards and the intricacies of childbirth experiences. To achieve this, we constructed an online questionnaire which was completed by a total of 10,657 respondents from Serbia, Montenegro, Bosnia and Herzegovina, and Croatia, who gave birth between 2000 and 2021. In order to minimise the influence of potential confounding variables resulting from changes in obstetric care practices over the past two decades, data analysis was limited to the participants who gave birth between 2016 and 2021 (N= 7,779). Data were analysed using descriptive statistics, as well as content analysis for an open-ended question regarding adverse experiences during childbirth and hospitalisation. The most significant findings of this study highlight widespread issues of bribery and corruption within maternity wards, with nearly 50% of the respondents across all four countries reporting the use of personal connections with hospital staff to secure adequate care. Psychological support post-childbirth was alarmingly insufficient, with fewer than

5% of women receiving any form of assistance, despite 28.5% to 35.0% of the participants reporting symptoms of postpartum depression. Particularly noteworthy outcomes of the content analysis were instances within the staff category, where the respondents reported various forms of mistreatment and substandard care. These results underscore the necessity for further dedicated research on this pivotal topic.

Keywords: *pregnancy, maternity wards, childbirth, corruption in healthcare, postpartum depression*

Introduction

Childbirth and the perinatal period encompass significant physical, psychological, and social transformations in a woman's life, accompanied by a marked increase in the utilisation of healthcare services (Rodríguez & Rivières-Pigeon, 2007). Given these profound changes, a certain standard of care is essential to ensure that both the newborn and the mother can thrive and adapt during this critical transitional phase. The concept of "quality of care" has been defined in various ways throughout the literature, with fewer definitions specifically addressing maternity care. However, some studies have clarified this concept by identifying key elements: ensuring a minimum standard of healthcare for all pregnant women and their newborns, providing enhanced care for those who require it, and striving for optimal outcomes (Pittrof et al., 2002). Historically, maternal health was largely overlooked in policy development, with primary attention directed towards infant health. Maternal well-being was often reduced to technical and medical considerations until the feminist movement brought sexual and reproductive rights to the forefront, advocating for their recognition as critical global issues (Sen et al., 2018).

Since that time, numerous studies worldwide have explored various dimensions of childbirth and the quality of maternity care. Research has consistently demonstrated that both the quality of maternity care and interpersonal support play a pivotal role in shaping women's childbirth experiences. Inadequate care has been linked to adverse outcomes, such as postpartum depression and anxiety, underscoring the critical importance of compassionate and supportive care practices during this period (Rodríguez-Almagro et al., 2019; Leeds & Hargreaves, 2008). Furthermore, obstetric violence has been shown to have lasting effects on patients' willingness to seek medical care, extending beyond gynaecological services (Perrotte et al., 2020).

Key factors influencing women's satisfaction with childbirth include effective communication, physical comfort, and emotional support provided by healthcare professionals (Goodman et al., 2004; Gibbins & Thomson, 2001). For example, a woman's perceived sense of control during labour is a crucial determinant of a positive birth experience (Bryanton et al., 2008). Similarly, the provision of breastfeeding support in maternity wards is instrumental in enhancing maternal satisfaction, which, in turn, can facilitate early bonding and improve infant health outcomes (Pérez-Escamilla et al., 1994). Recent research on this topic recommends implementing a Baby-Friendly Hospital Initiative (BFHI) in maternity wards, as it promotes rooming-in, allowing mothers and infants to remain together to facilitate breastfeeding. This approach helps mothers recognise and respond to their infants' needs. Additionally, the implementation of a mandatory 20-hour World Health Organization breastfeeding counselling training for maternity ward staff has been proposed to enhance support (Živković Šulović, 2024). Despite these positive developments, research continues to highlight persistent issues of disrespect and abuse in maternity care, particularly in low-resource settings, which can significantly undermine the quality of the childbirth experience (Freedman et al., 2014; Sen et al., 2018).

These findings underscore a global concern; yet, in the Balkan countries—namely Serbia, Bosnia and Herzegovina, Montenegro, and Croatia—research and policy efforts addressing maternity ward conditions and the quality of childbirth experiences remain limited. Despite maternal health being a priority according to World Health Organization (WHO) standards (Chalmers et al., 2001), existing studies suggest that maternity wards in the Balkans frequently fail to meet essential care standards, with cultural factors potentially exacerbating these deficiencies (Chalmers, 1997). In Serbia specifically, Stanković (2017) identifies a range of challenges faced by women in public healthcare institutions, highlighting common themes of isolation, abandonment, poor communication, and a lack of agency. For instance, healthcare practitioners often controlled the birthing process with minimal communication or consideration for the woman's subjective experiences or preferences, fostering a sense of helplessness (Stanković, 2017). Similarly, a study conducted on a sample of over 1,000 women in Croatia revealed that nearly one-third of participants felt excluded from the decision-making process before, during, or after labour. Additionally, more than one-third of the respondents

reported experiencing various forms of both verbal and physical abuse. The research further underscores concerns regarding maternity ward conditions, particularly the failure to meet women's basic needs, such as access to food and water, as well as inadequate hygiene standards in maternity rooms (Cvitkušić, 2021). In like manner, research conducted in collaboration with the Ministry of Health and the UNICEF Country Office in Montenegro, aimed at evaluating the quality of maternal and neonatal services in the country, identified key areas for improvement, including the provision of private delivery rooms and companionship, the reduction of caesarean delivery rates, enhanced preparedness for obstetric and neonatal emergencies, improved counselling services, and increased maternal involvement in the decision-making process (Hodorogea et al., 2023).

The studies mentioned above, while significant, represent only a small subset of research addressing this issue within the Balkan countries. Therefore, the primary objective of this research was to broaden the scope by examining conditions in maternity wards and childbirth experiences across Serbia, Montenegro, Bosnia and Herzegovina, and Croatia. This study aims to provide a more comprehensive picture of the maternity care environment in these countries, focusing on factors such as healthcare staff interactions, facility conditions, emotional and psychological support, and potential issues like bribery and preferential treatment. By developing a comprehensive questionnaire that includes both quantitative measures and open-ended responses, we seek to capture the nuanced experiences of women in this region and explore how systemic issues—such as inadequate communication, emotional support, and a lack of patient agency—impact overall satisfaction with childbirth experiences. Ultimately, this study seeks to expand the discourse on maternity care in the Balkans by identifying areas in need of policy reform. By contributing empirical data, the findings can serve as a resource for policymakers and healthcare providers, helping to implement changes that ensure more respectful, supportive, and empowering childbirth experiences across the region. The main aim of the study was to present and make sense of the data collected in order to create a starting point and set a wider framework for future research which will dive deeper into more specific topics and analysis.

Method

Data collection

This study uses a descriptive research design to examine the situation in relation to maternity ward conditions and the delivery experience in the period between 2016 and 2021. This approach facilitated the collection of a diverse array of data, which was particularly significant given the absence of prior large-scale studies in Serbia, Croatia, Montenegro, and Bosnia and Herzegovina. The main aim of the study was to present and make sense of the data collected in order to create a starting point for future research.

The data used in this study were collected using an online questionnaire created by the authors of the study. The data collection lasted from August 27 to September 14, 2022. Within a two-week period, a sample of over 10,000 participants was obtained. The feasibility of this recruitment approach can be attributed to the increased accessibility of online survey distribution through social media platforms. Notably, influencers with substantial followings, some exceeding 100,000 and active in advocacy, significantly contributed to participant recruitment by sharing a link to the Google Form. This strategy generated over 2,000 responses within a few hours. Furthermore, influencers identified as “mother influencers” effectively targeted the desired demographic, amplifying both the reach and relevance of the survey. The sample was non-random; however, its substantial size and the inclusion of participants from multiple countries enabled a high degree of heterogeneity across socio-demographic variables. When participants clicked on the link shared on social media platforms, they were redirected to the Google Forms survey. First, they received a brief description of the study and its purpose, the voluntary nature of participation and the anonymity of their responses. If the participants

proceeded to answer the questions after reading the introduction, it was assumed that they had given their informed consent. Firstly, the participants completed a series of 8 questions on socio-demographic variables such as country of origin, their age at childbirth, year of birth, and the type of labour they had. They then answered a total of 41 questions about hospital conditions, treatment by hospital staff and their personal perceptions. The questionnaire contained both Likert and binary (yes/no) items as well as questions with open answers. In the first question, the participants were asked about their most positive memories of the whole childbirth experience and the hospital stay, and in the second question about their most negative memories.

Sample

Initially, the data gathered included all the participants who gave birth between 2000 and 2021. However, to minimise the influence of potential confounding variables resulting from changes in obstetric care practices over the past two decades, data analysis was limited to the participants who gave birth between 2016 and 2021. This approach ensured that only the most relevant and contemporary data were considered. Notably, this subsample represents 75.1% of the original sample.

The sample consisted of 7779 women from Serbia, Croatia, Montenegro and Bosnia and Herzegovina. Most of the participants were from Serbia (N = 5,302), followed by Bosnia and Herzegovina (N = 1,388). The majority were between 26 and 30 years old (42.5%) and between 20 and 25 (29.5%). For 81.8% of the participants, it was their first childbirth. Additionally, 57.3% gave birth vaginally, 21.3% had a cesarean section, and 21.3% received an epidural during labour. A detailed sample description is provided in Table 1.

The inclusion criteria required the participants to have given birth on the territory of Serbia, Montenegro, Bosnia and Herzegovina, and Croatia between 2016 and 2021. The individuals who did not meet either of these criteria were excluded to ensure that the data accurately reflected the experiences of the target population. The sample size was not determined on a power analysis; instead, the goal was to recruit as many participants as possible to maximise the representativeness of the findings.

Table 1
Sociodemographic profile of the sample by countries

		Serbia	Montenegro	Bosnia and Herzegovina	Croatia
Participants		68.2%	9.4%	17.8%	4.6%
Age	<19	1.3%	1.2%	1.5%	0%
	20-25	27%	28.5%	37.3%	38.9%
	26-30	42.5%	46.6%	40.3%	41.1%
	31-35	22.7%	18.8%	17.4%	16.3%
	36-40	6%	4.8%	3.2%	3.3%
	41+	0.5%	0.1%	0.3%	0.3%
First childbirth	Yes	81.8%	79.7%	82.9%	82%
	No	18.2%	20.3%	17.1%	18%
Due date	Expected	63.2%	64.2%	55.1%	48.5%
	Early	11.8%	11.6%	16.6%	14%
	Late	25%	24.2%	28.3%	37.5%
Type of childbirth	Natural	54.5%	64.2%	63.6%	61.1%
	Epidural	24.6%	14%	11.2%	27%
	Cesarean delivery	20.9%	21.8%	25.2%	11.9%

Data analysis

IBM SPSS 24.0.0.1 was used to analyse the data collected from the online survey. Since the main aim of this research was to present findings from the questionnaire, descriptive statistics were employed.

Results

Descriptive statistics

The descriptive analysis provides a detailed overview of the systemic and psychological challenges faced by women during and after childbirth across Serbia, Montenegro, Bosnia and Herzegovina, and Croatia. The findings highlight prevalent issues such as bribery, corruption, a lack of psychological support, and postpartum depression. The summarised data are presented in Table 2.

Table 2

Summary of key findings on maternity ward conditions and postpartum experiences by country

Category	Serbia N (%)	Croatia N (%)	Bosnia and Herzegovina N (%)	Montenegro N (%)
Used personal inside connections to ensure proper care	3044 (57.4)	145 (40.8)	628 (45.2)	307 (41.8)
Provided informal financial compensation to medical staff	2625 (49.5)	44 (12.4)	947 (68.2)	528 (71.9)
Received/were offered psychological support after childbirth	172 (3.2)	14 (3.9)	20 (1.4)	32 (4.4)
Experienced symptoms of postpartum depression	1527 (28.8)	101 (28.5)	457 (32.9)	257 (35.0)
Received support from family and/or partner for postpartum depression	999 (18.8)	62 (17.5)	300 (21.6)	172 (23.4)
Sought professional help for postpartum depression	256 (4.8)	13 (3.7)	58 (4.2)	35 (4.8)

Note. Data represent affirmative responses only. Values are shown as frequency and percentage N (%).

The findings presented in Table 2 reveal notable disparities in maternity care experiences across the analysed countries. In response to item 47, “*Did you use personal or professional connections to ensure you received appropriate care during childbirth?*”, the highest proportion of affirmative responses was recorded in Serbia (57.4%), while lower frequencies were reported in Bosnia and Herzegovina (45.2%), Montenegro (41.8%), and Croatia (40.8%). Similarly, item 42, “*Did you provide financial compensation to a doctor, anaesthetologist, or midwife for their services?*”, showed substantial variation, with the highest prevalence in Montenegro (71.9%) and Bosnia and Herzegovina (68.2%), compared to significantly lower rates in Serbia (49.5%) and especially Croatia (12.4%). Access to psychological support was reported as limited across all countries. In response to item 43, “*Were you offered a conversation with a psychologist in the hospital to address any postpar-*

tum issues, such as bonding with your baby, body image concerns, the childbirth experience, breastfeeding challenges, or family relationships?”, only 3.2% of the respondents in Serbia, 3.9% in Croatia, 1.4% in Bosnia and Herzegovina, and 4.4% in Montenegro indicated they were offered such support. Despite the low availability of psychological support, a considerable number of women reported experiencing postpartum mental health difficulties. In response to item 44, “Did you experience symptoms of postpartum depression?”, between 28.5% (Croatia) and 35.0% (Montenegro) of the respondents indicated they had experienced such symptoms. Among those who reported postpartum depression, item 45, “If you experienced postpartum depression, did you feel supported by your partner or close family?”, revealed that the proportion of women receiving family or partner support ranged from 17.5% (Croatia) to 23.4% (Montenegro). Finally, item 46, “If you experienced postpartum depression, did you seek help from a psychologist or psychotherapist?”, showed that seeking professional help was generally low across all countries, ranging from 3.7% in Croatia to 4.8% in Serbia and Montenegro.

Content Analysis

In addition to the descriptive statistics, a content analysis was conducted on one of the open-ended questions in the questionnaire (item 49: “What would you highlight as the most negative memory of childbirth and your hospital stay?”). This analysis employed a conceptual approach, aiming to quantify and examine the presence of a specific concept within the dataset. The primary objective was to explore the frequency of 15 predefined themes (as outlined in Table 3), which were identified through an initial review of the first 500 responses. It is important to note that the content analysis presented in this study covers only 10% of the total sample of the respondents who gave birth between 2016 and 2021, specifically 778 randomly selected responses to the open-ended question regarding the participants’ most negative experiences during childbirth and hospital stay (item 49). The Inter-Rater Reliability (IRR) was also calculated, yielding a high reliability coefficient of 88%, with three independent raters coding the responses.

Table 3
Results of the content analysis

Description	N (%)
Staff-related complaints: all complaints related to staff - negligence/behaviour/professionalism/shortcomings (midwives, doctors, any other staff)	351 (45.4)
Hygiene-related complaints: all complaints related to hygiene	25 (3.2)
Facility conditions complaints: complaints about the conditions of stay of all kinds; institution conditions as a whole/room/bathrooms (overcrowding, temperature, appearance...)	45 (5.6)
Food and meal complaints: complaints about food and meals	21 (2.5)
Multi-complaints: multiple complaints about hygiene, conditions, food, staff, fellow patients (statements with at least 2 factors combined)	97 (12.5)
Overall negative feedback: complaints explicitly stating that everything is bad	33 (4.3)
Complaints about fellow patients	11 (1.4)
No complaints: everything is/was okay	78 (10.1)
Emotion-related complaints: complaints in the form of a spectrum of various negative emotions (fear, loneliness, uncertainty, etc.), whereas a lack of information and similar do not fall into this category as it is related to staff	5 (0.7)
Visitor restrictions complaints: complaints about visitor restrictions	5 (0.7)

Pain and childbirth experience complaints: complaints about the childbirth experience/pain (where specific complications and staff are not mentioned)	23 (3.0)
Non-staff-related complications: complaints about various complications before/during/after childbirth that are not related to staff (otherwise categorised as "S")	35 (4.3)
Corruption-related complaints: complaints explicitly mentioning corruption, bribery, "connections"	17 (2.2)
Private hospital: childbirth in a private hospital or suite	1 (0.1)
Breastfeeding complaints: complaints related to breastfeeding (only if not caused by staff incompetence, otherwise categorised as "S")	2 (0.3)
(Other): other complaints that cannot be categorised into any of the listed categories; empty fields; punctuation marks and other unintelligible symbols.	25 (3.2)
Disagreement: cases where all three raters assigned different categories to an item	4 (0.5)

Note. The table presents the frequency and percentage of coded categories assigned by three independent raters. The category DIS (*Disagreement*) represents cases where all three raters assigned different categories to an item, indicating a complete lack of agreement. In cases where two raters assigned the same category while the third assigned a different one, the majority decision was adopted as the final categorisation.

As presented in Table 3, nearly half of the randomly selected respondents identified interactions with hospital staff as the most negative aspect of their hospital stay (45.4%). Representative responses include: "I endured doctors and assistants pressing on my stomach, but the most terrifying experience during childbirth was the nervous and rude midwife." (respondent from Serbia), "I was accused of being spoiled, my stomach was pressed on, and there was a lack of interest in assisting with breastfeeding or helping me when my baby cried through the night." (respondent from Bosnia and Herzegovina), and "One of the nurses lost her temper when I asked for pain medication while she was watching a TV series. I didn't even dare to use a call button, I had to reach out to her myself, even though I was cut, torn, and stitched." (respondent from Croatia). Following this, the next most frequent category of complaints (12.5%) involved multiple issues, such as hygiene, hospital conditions, food, staff behaviour, and the conduct of fellow patients. Examples from this category include: "Well there are more things—no showerhead in the shower cabin, and the curtain is so blood-stained that it cannot be cleaned. I did not receive any medication for the headache following a challenging birth, despite waiting for three hours." (respondent from Serbia) and "Bad bathroom hygiene and the staff did not focus a lot on us women who had a C-section. There was no hot water, soap, or toilet paper; you had to bring those things from home. Horrible and ripped hospital gowns." (respondent from Montenegro). The least frequent complaints were related to visitor restrictions, breastfeeding issues not involving staff treatment, and experiences related to childbirth in private hospitals or suites.

Discussion

The presented study on maternity ward conditions and childbirth experiences, which includes data from a substantial sample across Serbia, Croatia, Montenegro, and Bosnia and Herzegovina, makes an important contribution to addressing a significant gap in the existing literature. The findings underscore critical deficiencies, highlighting staff negligence, unprofessional behaviour, and inadequacies as the most significant issues. Facility conditions and hygiene also emerged as notable concerns, alongside pain and childbirth experiences. These insights provide a valuable foundation for future research and offer a framework to guide efforts aimed at improving maternity care in the region.

The findings of our study illustrate considerable gaps in maternity care practices when evaluated

against the World Health Organization (WHO) standards. WHO emphasises the necessity of high-quality maternity care that respects women's rights and ensures the health of both mothers and newborns. While our results indicate some positive aspects, such as general satisfaction among many participants, significant shortcomings were also noted in critical areas, including pain management, procedures that have been used, and postnatal care. These discrepancies are concerning, particularly in light of WHO recommendations that prioritise compassionate care and patient dignity during childbirth (Chalmers et al., 2001; Freedman et al., 2014).

Laws vs. Reality

National legislation, including the Law on Health Protection ("Official Gazette of RS", Nos. 25/2019 and 92/2023) and the Law on Patient Rights ("Official Gazette of RS", Nos. 45/2013 and 25/2019), establishes robust protections for the rights of pregnant women, aiming to ensure dignity and a minimum standard of care during childbirth. However, our findings reveal a concerning disparity between these legal provisions and the lived experiences reported by the participants, highlighting maternity care deficiency more as a systemic problem and less an individual one. This misalignment between legislative intent and practice highlights the urgent need for policy reforms, particularly in addressing bribery and neglect. Key rights enshrined in Serbian law include the right to privacy, ensuring the confidentiality of personal and medical information, and informed consent, which empowers women to make educated decisions regarding their care. These provisions are integral to fostering autonomy and respect throughout the childbirth process. The law also upholds the right to choose a birthing environment, the presence of a support person during labour, and access to adequate pain relief and anaesthesia, ensuring physical comfort and emotional support. Furthermore, postpartum care, including mental health services and breastfeeding guidance, is mandated to promote comprehensive well-being for mothers and newborns. Crucially, women have the legal right to file complaints regarding violations of these rights, promoting accountability within the healthcare system. Despite these protections, our results indicate that many women experience a significant gap between these standards and the realities of care, emphasising the need for stronger enforcement mechanisms and systemic improvements to align practice with legislative and ethical mandates.

Our findings reveal that while significant progress has been made in establishing legal protections for pregnant women, systemic issues persist that undermine the childbirth experience. Historically, problems such as neglect, a lack of privacy, and insufficient pain relief were pervasive concerns. Today, despite robust national legislation aimed at safeguarding dignity and rights during childbirth, these issues remain prevalent, along with newer challenges like bribery and inconsistent enforcement of care standards. Cultural factors and systemic deficiencies continue to shape negative experiences for a significant number of women, indicating a persistent gap between legal provisions and practice. This highlights the need for stronger implementation of existing laws, increased accountability, and culturally sensitive interventions to bridge the divide and ensure dignity, respect, and quality care for all.

From Past to Present

Building upon the identified discrepancies between legislative frameworks and practical challenges, it is crucial to examine the historical trends that may have contributed to these systemic issues. Our findings are consistent with prior research that highlights systemic neglect, as well as instances of disrespect and abuse in maternity care (Sekulic, 2016; Sen et al., 2018). Although the majority of women reported pos-

itive experiences, a significant proportion encountered negative circumstances, underscoring the need for targeted interventions aimed at fostering cultural sensitivity among healthcare providers. This observation is essential in addressing the broader issues of disrespect and abuse documented in the existing literature (Rodríguez-Almagro et al., 2019).

As noted in the introduction, previous studies have identified persistent and significant issues within maternity care, such as poor communication, exclusion from decision-making processes, various forms of verbal and physical abuse, and substandard hygienic conditions in maternity wards (Stanković, 2017; Cvitkušić, 2021). Our findings corroborate these concerns, with content analysis revealing that nearly half of the respondents cited interactions with hospital staff—particularly communication with doctors and nurses, as well as concerns regarding professionalism or negligence—as their most unpleasant memory during hospital care. In addition to staff interactions, respondents also highlighted poor hospital conditions and hygiene as some of their most negative experiences.

However, our results also illuminate a critical and under-explored issue within maternity care: the influence of personal connections and informal financial compensation. In all four countries under study, nearly half of the respondents reported utilising personal connections to secure proper care. Furthermore, in Serbia, Bosnia and Herzegovina, and Montenegro approximately half of the respondents acknowledged offering informal financial compensation to hospital staff, a practice far less prevalent in Croatia. These findings underscore the need for more in-depth, focused research on bribery and preferential treatment, given the potentially severe implications they may have on the manner in which healthcare providers (mis) treat women.

An additional, significant area that has been insufficiently studied in these countries is postpartum depression. Our results indicate that approximately one-third of women experienced symptoms of postpartum depression, yet only a small fraction sought professional help or received support from their social networks. Prior studies have indicated a correlation between postpartum depression and the use of forceps or vacuum extractions during delivery, as well as with undergoing a cesarean section, particularly when women had planned and desired a natural birth (Juric, 2020). As Juric (2020) noted, postpartum depression is a critical issue that impacts various aspects of a mother's life and the well-being of those in her surrounding environment, with the potential to evolve into chronic depressive episodes. Given the considerable challenges faced by women experiencing postpartum depression, the prevalence of this condition and a lack of help-seeking behaviour among our respondents warrant further investigation and a deeper understanding, particularly regarding the potential link to women's interactions with medical staff and the procedures performed during childbirth.

Study Limitations and Directions for Future Research

This study serves as a foundational step for future research on factors influencing the childbirth experience. Conducted entirely online using convenience sampling, it likely reflects a sample biased towards women of certain ages, socioeconomic statuses, cultural backgrounds, and digital literacy levels. As a result, the findings may not fully represent the population of women who gave birth between 2006 and 2021 in Serbia, Montenegro, Croatia, and Bosnia and Herzegovina. Additionally, the reliance on descriptive analysis limits the study's ability to explore relationships between variables that could influence the childbirth experience in greater depth.

An additional limitation of this study pertains to the sociodemographic variables, as certain key aspects were not included in the questionnaire. Notably, the type of living situation (urban or rural) and the specific age of the respondents were omitted, with the participants only able to select from predefined

age ranges. This omission restricts the potential for comparisons based on sociodemographic factors. We acknowledge these shortcomings in the design of the questionnaire and recommend that future research incorporate a comprehensive range of sociodemographic variables to enable more thorough and accurate analyses.

Despite these limitations, the study offers valuable insights and opportunities for further exploration. Future research could apply factor analysis to uncover underlying dimensions affecting childbirth experiences and use inferential statistics to examine correlations between key variables. Such analyses might identify specific areas of hospital care requiring improvement to enhance antenatal and postnatal care

To address current sample biases, systematic sampling should be employed to ensure more inclusive and representative findings. Furthermore, qualitative analysis of open-ended responses—only conducted on 10% of the current dataset—should be expanded to the entire dataset. This would provide deeper insights into mothers' lived experiences and highlight targeted areas for intervention. Moreover, the comparison between the countries may be influenced by the sample imbalance, as the majority of respondents are from Serbia.

By addressing these gaps, future research can build on the present findings to develop a more nuanced understanding of childbirth experiences and propose strategies to improve maternity care across the region.

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