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Scoping Review
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A Scoping Review of Maternal Birth Experience in Low- and Middle-Income Countries from 2014-2024

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ABSTRACT

Backgroud: Childbirth experiences differ widely, shaped by cultural beliefs, socioeconomic status, healthcare infrastructure, and delivery location. In low- and middle-income countries (LMICs), limited access to quality care and higher maternal mortality rates deeply affect women's experiences and outcomes. While prior studies have typically examined economic, social, or structural influences independently, a comprehensive approach that integrates these domains is needed. This study aims to examine the economic, social, and structural factors influencing maternal experiences in LMICs and assess how these factors shape both the choice of delivery location and maternal care experience.
Subjects and Method: A literature search of studies from 2014 to 2024 was conducted using MEDLINE and Google Scholar. Controlled vocabulary (e.g., MeSH terms) and Boolean operators combined terms such as "midwives," "birth assistants," "LMICs," "hospital birth," and "maternal mortality rates." Only peer-reviewed quantitative and qualitative English-language studies examining maternal birth experience in LMICs were included. Grey literature, reviews, and opinion pieces were excluded. Findings were organized using a global framework on maternal health determinants.
Results: Of 114 articles identified, 8 met the inclusion criteria, covering studies from Bangladesh, Ethiopia, rural Sierra Leone, Kenya, rural Zambia, Chiapas (Mexico), and Eritrea. These studies revealed that maternal experience and delivery location are shaped by economic, social and structural factors. Hospital fees and informal costs discouraged facility-based births, while limited education, cultural norms and male-dominated decision-making reduced women's autonomy in choosing their delivery location. Structural challenges, including staff shortages, lack of privacy, and poor rural access, further limited hospital deliveries.
Conclusion: Maternal birth experiences in LMICs are influenced by hospital delivery costs, cultural beliefs, limited education and awareness, and inadequate healthcare facilities, which reduce access to quality care and undermine women's autonomy. Targeted interventions, such as affordable, culturally sensitive, and accessible healthcare and education-focused initiatives, are essential to enhancing maternal birth experiences and outcomes.

Keywords: birth experience, hospital birth, home birth, midwives.

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BACKGROUND

Maternal mortality represents a significant public health challenge, impacting low and lower-middle-income countries (LMICs) (Bauserman et al., 2020). In 2020, approximately 287,000 women died due to complications related to childbirth, with 95% of these fatalities occurring in developing nations 2024 (World Health Organization, 2024b). Maternal mortality in low, lower-middle- and upper-middle-income countries (collectively known as LMICs, according to the World Bank definition) may be influenced by inadequate socio-economic conditions, substandard quality of care, lack of well-trained healthcare personnel, inadequate infrastructure, and barriers to medical access. These factors can lead to an increased risk of maternal hemorrhage, complications, infections, and unsafe abortion practices (Dahab and Sakellariou, 2020). High-income countries typically ensure antenatal care and skilled birth attendants, and they predominantly facilitate institutional births, which can deliver appropriate emergency care in the event of complications (Shaw et al., 2016).

As shown by Bauserman et al. (2020), the majority of maternal deaths occur in LMICs, indicating different usages of hospital institutions. For example, in rural Chiapas, women may choose to deliver at home with the help of traditional birth attendants or midwives due to concerns of mistreatment in hospitals (Aranda et al., 2024), suggesting a potential link between delivery location and a positive birth experience. There are several factors influencing delivery location and maternal birth experience that can be broadly categorized into 3 main areas: economic, social, and structural. Economic factors, such as household income, spousal occupation, or care affordability, may influence where women give birth and how they perceive their care (Srivastava et al., 2015). Social factors like educational attainment, cultural expectations, or family traditions could also shape attitudes toward childbirth and healthcare utilization (Patel et al., 2021; Kifle et al., 2018; Withers et al., 2018). Structural factors, including the quality of health facilities, infrastructure reliability, and transportation facilities, might further affect delivery location and maternal birth experience (Srivastava et al., 2015; Gebregziabher et al., 2019).

The rationale for this research lies in the need to comprehensively understand the diverse economic, social, and structural factors influencing maternal birth experiences in LMICs. While previous studies have typically examined these factors individually or focused on specific countries or income groups, this review aims to explore all 3 domains within a single framework. By investigating the separate and combined impacts of economic, social, and structural factors on maternal experience and delivery location choices, this study seeks to provide

a clearer understanding of the complex dynamics shaping maternal birth experiences in LMICs. This review aims to examine the economic, social, and structural factors that influence maternal birth experiences with home and hospital births in LMICs, and to assess how these factors shape both the choice of delivery location and maternal care experience.

SUBJECTS AND METHOD

1. Study Design

This study is a narrative scoping literature review conducted between October 10 and November 5, 2024, and focused on studies published from 2014 to 2024. The study adhered to best practices for scoping review methodology and applied PRESS (Peer Review of Electronic Search Strategies) guidelines to enhance transparency and reproducibility, particularly in the search and selection process.

2. Inclusion Criteria

The review included free, full-text, peer-reviewed quantitative and qualitative primary research studies, published in English between 2014 and 2024. Eligible studies focused on maternal birth experiences, factors influencing delivery location, or the use of skilled birth attendants among women of reproductive age in LMICs who had experienced at least one live birth. Cross-sectional, analytical, or survey-based studies using interviews, focus group discussions, or thematic analyses were included.

3. Exclusion Criteria

Non-primary research studies (i.e., grey literature, reviews, books, non-academic reports, and opinion pieces) were not incorporated in this review. Additionally, any studies not available in English and published before 2014 were excluded. Studies that did not address maternal birth experiences, factors influencing delivery location, or the use of skilled birth attendants in LMICs were also omitted. Furthermore, papers relying solely on clinical outcomes without exploring women's perspectives were excluded.

4. Study Variables

The dependent variables were maternal birth experience, including home and hospital births. Independent variables were grouped into three categories: economic, social and structural factors.

5. Operational Definition of Variables

Maternal birth experiences were women's satisfaction with childbirth in hospital or home and the healthcare received.

Economic Factors were defined as direct or indirect costs associated with delivery that influenced women's choice of birth location.

Social Factors referred to cultural norms, family influence, education, male-dominated decision-making affecting maternal autonomy.

Structural Factors included the quality and accessibility of healthcare facilities, staff capacity and physical infrastructure such as transport systems.

6. Study Instrument

The literature search was conducted using MEDLINE and Google Scholar. Keywords such as "midwives," "birth assistants," "low- and middle-income countries," "hospital birth," and "maternal mortality rates" were combined using Boolean operators (AND/OR) to refine results. The PRISMA framework guided article selection and screening.

7. Data Analysis

M.P. and S.Q. performed data extraction using a standardized excel spreadsheet. Information on each included study was compiled into the sheet for further review, including publication year, country or countries of focus, participant population, main objectives, brief methodology summary and main findings. The analysis emphasized how maternal birth experience

was shaped by factors such as provider type, birth setting and structural influences. As a group, the relevance of each study's main findings was discussed and grouped into thematic categories based on a global framework on the determinants of maternal health that includes factors such as cultural norms, the economic system, and healthcare structures (Souza et al., 2024). This method of organization allowed for a cohesive understanding on how systemic, cultural and social contexts influence maternal birth experience across LMICs.

7. Research Ethics

Ethical approval was not required, as this review analyzed and synthesized data from previously published studies.

RESULTS

Based on Figure 1 show that in total, 8 studies were identified, as shown in the PRISMA flow chart detailing the study selection process (Figure 1). The studies focused on specific LMICs across the globe: Bangladesh, Ethiopia, Eritrea, Zambia, rural Mexico, Sierra Leone, and Kenya. The designs of these studies varied, including cross-sectional studies, interviews conducted in person and via telephone, and demographic and health surveys. The study participants were pregnant women and women of reproductive age. Table 1 comprehensively summarizes the findings, strengths, limitations, and potential solutions to the limitations. Table 2 provides a detailed overview of the study characteristics.

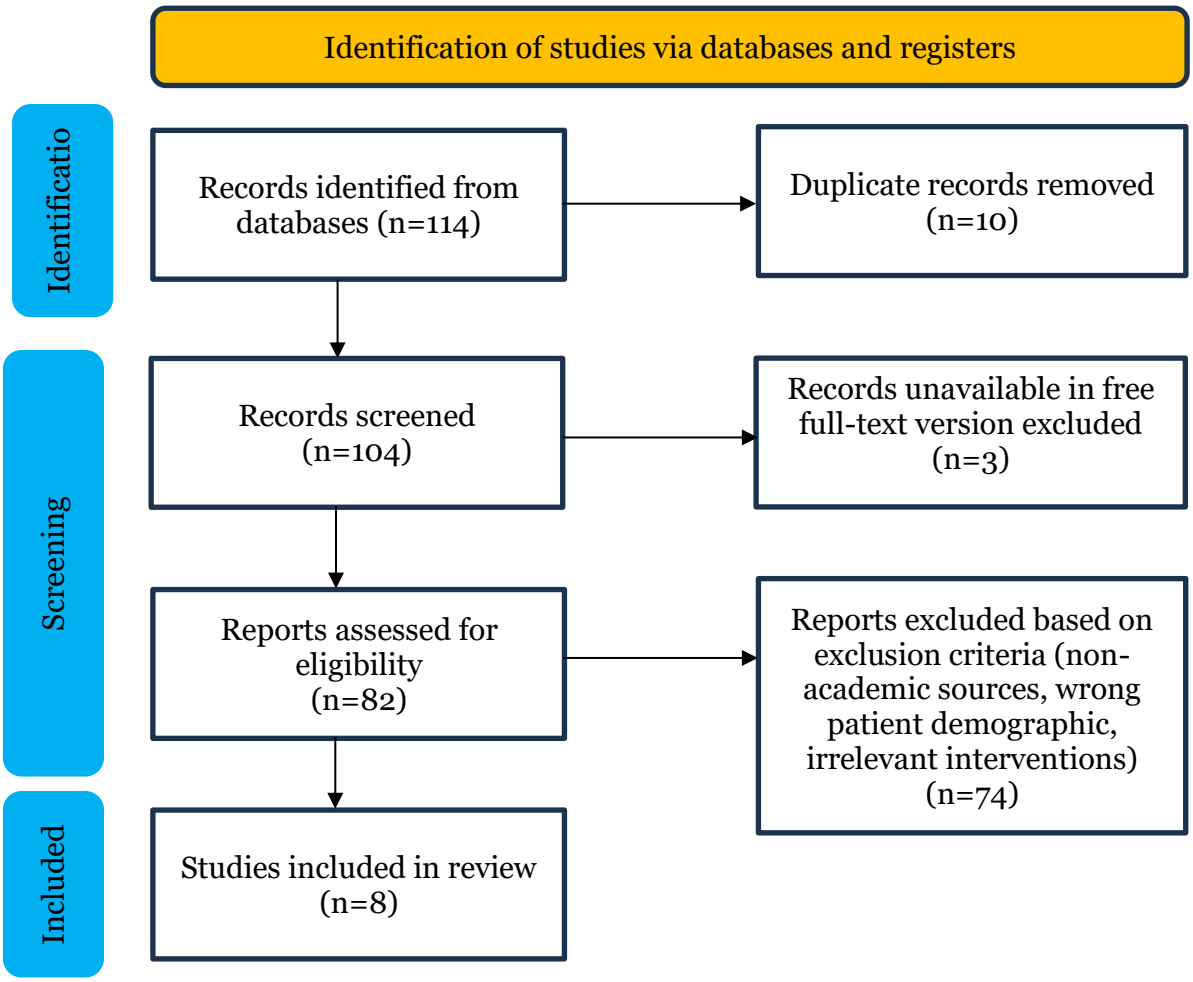

Figure 1. PRISMA chart detailing the study selection process

Table 1. Baseline characteristics of key studies included

Author (Year)	Country/ region	Design	Participants	Duration	Aim/ Purpose
Nahar et al. (2022)	Bangladesh (lower-middle-income country)	This research used data from the Bangladesh Health and Demographic Survey conducted from 2017 to 2018, which is characterized as a cross-sectional study.	The study included a weighted sample of 4,842 women who experienced a live birth within the 3 years preceding the BDHS(Bangladesh Demographic and Health Survey) 2017–2018 survey. For participants with multiple births during that period, only the first live birth was considered.	Unclear.	The objective of this study was to examine the factors at both the individual and community levels that influence the use of skilled birth attendants during childbirth in Bangladesh.
Kifle et al. (2018)	Eritrea (low-income country)	The research methodology employed in this study was a cross-sectional analytical design. A census sampling technique was implemented within the communities. The data collection involved structured questionnaires utilizing both closed and open-ended inquiries.	The study population consisted of 309 women of childbearing age, specifically those aged 15 to 49 years, who had at least one childbirth within 1 to 2 years by the time of data collection.	This study was conducted for 2 months, from August to September 2017.	The study aimed to determine factors that influence women's choice of delivery place in selected rural communities in Eritrea.
Aranda et al. (2024)	Rural Chiapas, Mexico (upper-middle-income country)	The research used a qualitative, exploratory framework, conducting semi-structured interviews with 20 women who had delivered in a public health facility in Chiapas within the 6 months prior to the interview. The interview guide was developed using the WHO health system responsiveness framework, focusing on the non-clinical and non-financial aspects of care. The data was analyzed using thematic analysis methodology.	The population of this study included twenty women who had given birth at the Compañeros En Salud (CES)-supported birthing center and adjacent basic community hospital in Ángel Albino Corzo, Villaflores Bicentenario hospital, Motozintla hospital, and Siltepec hospital, all health facilities in the Fraylesca and Sierra regions of Chiapas, Mexico.	Data collection activities were conducted between July 2022 and August 2022.	This paper aimed to understand the influence of non-clinical factors on women's birthing experiences in public health institutions in Chiapas.

Author (Year)	Country/ region	Design	Participants	Duration	Aim/ Purpose
Treacy et al. (2018)	Rural Sierra Leone (low-income country)	The research adopted a qualitative approach, incorporating focus group discussions and in-depth interviews with recently pregnant women and community members. To capture a diverse array of viewpoints, it employed partially homogeneous sampling for the focus group discussions and purposeful sampling for the in-depth interviews.	The population of the study included a total of 61 participants; among them, 22 participated in in-depth interviews and 42 in focus group discussions (3 participants were part of a focus group discussion and in-depth interviews).	The study took place between August and Decembe r 2013.	This study's objective aimed to explore the perceptions and decision-making processes of women and their communities during childbirth in rural Sierra Leone.
Sudhinar aset et al. (2023)	Peri-urban and urban Kenya (lower-middle-income country)	This research was conducted in-depth, individual, qualitative telephone interviews in Nairobi and Kiambu County, Kenya. Each participant was interviewed in Kiswahili.	This study conducted interviews with 28 women who had undergone home births.	Unclear.	This study investigated the economic, social, and healthcare system factors related to home births in Kenya.
Sialubanj e et al. (2015)	Rural Zambia (lower-middle-income country)	This study collected data using focus-group discussions with women living in areas with low institutional delivery rates. Additionally, in-depth interviews were conducted with traditional birth attendants, family members and members of the community to assess home birth decision-making and views on birth attendant services.	Homebirths w traditional birth attendants: sociocultural beliefs/low education (bangladesh - edu) Fear of hospital procedures (Bangladesh - CS Low resource hospitals	Unclear.	Assess the reasons for women giving birth at home and whether they choose to be assisted by traditional birth attendants.
Perkins et al. (2018)	Bangladesh (lower-middle-income country)	This study used a cross-sectional survey and it was conducted in Brahmanbaria district. Main outcomes included choice of delivery location and actual delivery location. Binary logistic regression was used to assess	1367 women who had a birth history within 12 months prior to survey start were interviewed.	Data collected between March and May 2018.	Investigate decision-making of delivery location and the various factors influencing this choice.

Author (Year)	Country/ region	Design	Participants	Duration	Aim/ Purpose
		associations of these outcomes with background characteristics, and multiple logistic regression was used to adjust for the effect of confounders.			
Chernet et al. (2019)	Ethiopia (Low-income country)	This study used data from the 2016 Ethiopia Demographic Health survey. Sample selection used a 2-stage cluster design and a mixed effect logistic regression model was applied.	No people participated in the study as demographic data was used.	Unclear.	Identify factors influencing home birth.

Table 2. Study selection criteria and their corresponding outcomes

Article Number	Study/ Author	Study Limitations	Possible solutions	Outcomes
1	Nahar et al. (2022)	This study did not consider factors affecting skilled birth attendant utilization, such as transportation, distance to healthcare facilities, geography, delivery costs, and other medical conditions.	These limitations could be corrected by including the influence of the factors left out.	This article displayed how cultural beliefs, level of education, and financial status could influence a couple's decision to utilize a skilled birth attendant for pregnancy. Muslim women were less likely to seek skilled birth attendant care due to traditional beliefs and conservative culture, similar to what is found in Article 6. Not only that, but couples with higher educational status were also more likely to see a skilled birth attendant. Couples that experienced poverty were less likely to seek skilled birth attendants.
2	Kifle et al. (2018)	Recall bias may affect the women's recollection of events, potentially distorting the accuracy of their memories. Additionally, the qualitative nature of the responses prevents establishing a confirmed cause-and-effect relationship.	The potential recall bias could be solved using hospital records rather than the women's records of their choices. The qualitative evidence could be solved by finding a specific number of people.	This article found that in Eritrea, most deliveries happen at home. The higher the husband's education level, the more likely their wives were to deliver in a health facility. Poor women were less likely to give up in health facilities due to financial constraints and abuse from healthcare personnel. These findings relate to those of Article 1 as they both show how couples with higher education levels are more likely to receive professional

Article Number	Study/ Author	Study Limitations	Possible solutions	Outcomes
				care. However, this article mentions that the husband's education level tends to matter more in this decision, revealing the prevalence of gender inequality, similar to what is stated in articles 4 and 6.
3	Aranda et al. (2024)	Possible social desirability bias due to the data collector's association with CES, the NGO providing care at the birthing center. Efforts were made to reduce this bias through assurances of confidentiality and carefully designed questions. Additionally, since participants gave birth during the COVID-19 pandemic, findings may have limited generalizability to other periods due to ongoing resource shortages and elevated provider stress during that period.	Social desirability bias can be reduced by using independent interviewers who are not affiliated with CES or the birthing center. Generalizability of the study can be increased by including women who gave birth before and after the pandemic or by conducting a longitudinal study to examine if the perceptions of non-clinical factors affecting birth experience evolves over the years, especially post pandemic.	The study identified 16 themes across 8 domains of the WHO health system responsiveness framework, highlighting key non-clinical aspects that shape women's birth experiences in Chiapas.Outcomes included barriers to timely care, the importance of adequate food and hydration, role of companionship and aspects of the healthcare facility. These findings underscore gaps in the responsiveness of public health services in Chiapas and provide a foundation for improving maternal birth experience.
4	Treacy et al. (2018)	There were no prevalent limitations.	Not applicable.	This article examined the quality of obstetric care in Sierra Leone, where hospital care was deemed unsatisfactory. Families were not allowed in the labour room, and hospital staff were unwelcoming, echoing issues raised in Article 3. Poor families faced transport fees, limiting their access to higher-quality care, as noted in Article 3. Gender inequality was prevalent, with women requiring their husband's permission for birthing procedures, a theme also present in Articles 2 and 6. Additionally, many women lacked education about childbirth, and hospital

Article Number	Study/ Author	Study Limitations	Possible solutions	Outcomes
				infrastructure was inadequate.
5	Sudhinaraset et al. (2023)	This study was limited to data from peri-urban Kiambu and urban Nairobi counties in Kenya, which represented only small regions. The findings may not apply to other areas of Kenya.	Data could be collected from larger cities and counties that account for both urban and rural areas, providing a set of data.	This article found that although women wanted to give birth at a hospital, they were inclined to give birth at home due to the conditions of the pandemic. Many women were afraid of contracting COVID-19, and the curfews made it very difficult to access transportation. The healthcare system was also deteriorating because of the pandemic. It was dangerous for women to go out at night, and because of the curfews, many of them faced violent encounters with law enforcement. Couples could not pay hospital and transportation fees, a hurdle mentioned in Articles 3 and 4.
6	Sialubanje et al. (2015)	This study utilized focus-group discussions and in-depth interviews, which require voluntary participant sign-up. There is no information on why people may have avoided participating in the study. Husbands were also not interviewed.	Though perhaps out of scope of this study, reasons for non-participation could be identified and recruitment strategies reconsidered.	TBAs were shown to fill important staffing shortages in healthcare institutions. Deciding to deliver in a clinic was also more likely for younger women, those that experienced previous complications or had less experience with childbirth. A negative attitude towards nurses was present. The main factor influencing delivery location was the dependence on the husband for decision-making power and financial support. There was more trust, familiarity and confidence in skills of TBAs to perform deliveries at home.
7	Perkins et al. (2018)	Recall bias as well as social desirability bias are potential limitations due to the survey method. Qualitative analyses were also not conducted.	The incorporation of qualitative study techniques can further strengthen the study. Steps were also taken to recruit and train data collectors from local communities to reduce potential for bias.	two-thirds of women planned to give birth at home. Bigger families, lower education level and belonging to a lower wealth quintile were factors associated with homebirth. Specifically, women giving birth at home did not consider facility birth to be important, citing factors such as lack of money (20%), fear of Cesarean section (17%) and not being allowed facility birth by husbands and family members

Article Number	Study/ Author	Study Limitations	Possible solutions	Outcomes
8	Chernet et al. (2019)	None	Not applicable.	(10%). Of the 10,622 women included in this study, 67.2% gave birth at home. In rural areas, 77.9% had homebirths, with 20.4% of urban women delivering at home. 80.8% of uneducated women delivered at home and wealth was also identified as a factor influencing delivery location, similar to the above studies. These results were supported by a mixed effects logistic regression.

Thematic analysis revealed associations between economic, social and structural factors and maternal birth experience and delivery location:

Economic Factors: The economic landscape was a significant factor that represented a major influence on the choice of delivery location. Several studies showed that poor women living in lower-middle-income countries (namely Eritrea, Kenya, and rural Zambia) cannot afford hospital births, leading to more home deliveries that limit access to necessary emergency interventions (Sialubanje et al., 2015; Kifle et al., 2018; Chernet et al., 2019; Straneo et al., 2024; Sudhinaraset et al., 2023; Treacy et al., 2018; Morris et al., 2023). Additionally, costs beyond hospital fees, including bribes and high-quality newborn items (symbol of social standing), further discouraged hospital births (Treacy et al., 2018; Mayra et al., 2021). Studies conducted in Eritrea and Sri Lanka have shown that women from low socioeconomic backgrounds often faced mistreatment from medical staff if they could not offer bribes, which deters hospital deliveries (Bohren et al., 2014; Kifle et al., 2018; Rishard et al., 2021). These barriers women faced strip away their decision-making autonomy concerning delivery, thereby making them feel powerless in hospitals (Treacy et al., 2018). Health providers often employed abusive behaviour as a form of "punishment" for perceived "non-cooperation" in the name of achieving good health outcomes, revealing how mistreatment was justified as part of "quality care"(Bohren et al., 2020). Other factors affecting the risk of mistreatment included social status, physical appearance of the patient, family support, and culture shown in a study from India, reflecting the multi-faceted nature of mistreatment in delivery facilities (Mayra et al., 2021).

Social Factors: Culture and social norms shaped a woman's tendency to seek healthcare services and how she and society believe a baby should be born. Home births with non-skilled traditional birth attendants (Sialubanje et al., 2015; Chernet et al., 2019) were more common in lower resource countries due to sociocultural beliefs and lower educational levels (Brunton et al., 2021); moreover, in Bangladesh, Muslim women were less likely to use skilled birth attendants due to conservative, traditional beliefs (Nahar et al., 2022). The preference for home birth simultaneously showed that women are most comfortable with what is familiar. Fear of hospital delivery and procedures, such as Cesarean sections and

episiotomies, also contributed to the preference for home births. (Sialubanje et al., 2015; Roro et al., 2014). Fear of giving birth in hospitals reflected a lack of education and awareness of hospital procedures (Roro et al., 2014). A general trend showed that higher educational attainment in couples led to an increased likelihood of skilled birth attendant usage and facility births due to increased autonomy, decision-making ability, economic ability, and health-seeking behaviours (Nahar et al., 2022), suggesting that women of different education levels have different expectations and birth experiences.

In patriarchal societies, where men hold the authority to make decisions within the family sphere, the husband's education level often influenced the birth location (Kifle et al., 2018; Nahar et al., 2022; Treacy et al., 2018). For instance, in Eritrea, though most deliveries happen at home, the decision is determined mainly by the husband's level of education; the higher it is, the more likely their wives are to deliver in a facility (Kifle et al., 2018). This point brings up the issue of autonomy, in that women perceive their experience with the context that someone else made the choice of delivery location for them. This further emphasizes the importance of this study to highlight factors affecting the choice and to interrogate how they impact maternal birth experience in particular. In many cases, though men had the decision-making power, they were not allowed to witness the birth, thus being utterly ignorant of the birth process (Treacy et al., 2018).

Other factors contributing to birth experience included the ability to choose the care provider. It was observed that women often felt comfortable with female providers, such as familiar female nurses or midwives while giving birth in facilities (Aranda et al., 2024; Srivastava et al., 2015). Moreover, A study conducted in Mexico, Guatemala, and Panama, it was found that women were satisfied with their delivery experience based on a community health worker's presence and their main provider's ability to speak an Indigenous language (Colombara et al., 2016). These studies showed that social support and perceived familiarity between patients and their healthcare providers contributed to positive birth experiences. Srivastava et al. (2015) suggests that high maternal satisfaction in developing countries may reflect limited awareness, rather than genuinely high quality care. In low resource settings, women may normalize substandard treatment due to reduced expectations shaped by limited exposure to formal healthcare (Srivastava et al., 2015).

Structural Factors: The healthcare system in LMICs presents specific circumstances in terms of accessibility of care and availability of resources. Studies have shown that limited healthcare resources and staff, such as midwives attending multiple women at once, can impact the birth experience in low-middle-income countries (Srivastava et al., 2015; Sudhinaraset et al., 2023; Afaya et al., 2020).

In India, limited resources for maternal care and more patients seeking care in district hospitals compared to community health centers resulted in an increased workload and decreased patient care quality (Jha et al., 2017). In a study conducted by Mayra etal. (2021), women in some maternity facilities reported experiencing various forms of disrespect and mistreatment, including physical and verbal aggression by healthcare professionals. It was reported that the number of births has dramatically increased while the number of staff stayed the same, thus causing midwives to be overburdened and frustrated (Mayra et al., 2021). Similarly, low facility resources, staff shortages, and inadequate training hindered

midwives from providing quality care (Sialubanje et al., 2015). Privacy levels also influenced women's satisfaction with their childbirth experience. Visibility to other patients and patrons during vaginal examinations and emergency cesarean sections, negatively impacted overall experience (Srivastava et al., 2015; Afaya et al., 2020). A study conducted in rural Mexico showed that having a hygienic, adequately spacious environment and hot water, food, and drink contributed positively to birth experience (Aranda et al., 2024).

Women in rural lower-middle-income countries struggled to access healthcare services compared to women in urban areas, leading to higher rates of home births and decreased use of antenatal care (Sialubanje et al., 2015; Islam et al., 2022; Straneo et al., 2024). Access was primarily influenced by difficulties in transportation, which affected women's ability to reach hospitals in rural lower-middle-income countries. High transportation costs, curfews, and violence during travel were identified as obstacles to giving birth in healthcare facilities for women in poverty (Aranda et al., 2024; Sudhinaraset et al., 2023; Treacy et al., 2018). Furthermore, lack of healthcare facilities was one of the many reasons home births were common in rural lower-middle-income countries. Both limited options for transportation and the reduced number of hospitals in rural areas led to delayed care and negative labour experiences (Aranda et al., 2024).

Table 3. Summary of themes identified in the results

Category	Specific Factor	Effect on Delivery Location and Maternal Birth Experience
Economic	Cannot afford to deliver in hospitals.	Women must provide at home and cannot access emergency interventions.
	Cannot afford other items associated with hospital birth (nicer newborn blankets, bribes for healthcare providers).	Women are deterred from hospital births due to possible mistreatment.
	Abuse from healthcare providers.	Deterred women from delivering in hospitals—negative impact on the birth experience.
Social	Traditional cultural customs.	Preferred home births and non-skilled birth attendants.
	Low awareness of hospital procedures.	Fear of hospital procedures increased home births.
	Educational attainment.	More educated women were more likely to deliver in a hospital. They also exhibited more health-seeking behaviour and took ownership of their care.
	Husband's education level	Women with husbands who had higher educational attainment were more likely to deliver in a hospital, as these women often had limited autonomy in decision-making.
	Choice of care provider.	The ability to make this choice positively affects maternal birth experience.
Structural	Heavy hospital staff workload.	Decreased quality of care in hospitals.
	Resource shortages.	Reduces maternal birth experience in hospitals.
	Rural access to healthcare facilities.	Higher home birth rates are due to the decreased number of facilities in rural areas.

Category	Specific Factor	Effect on Delivery Location and Maternal Birth Experience
	Transportation to facilities.	There is low access to transport to the hospital, so women must give birth at home.

Table 3 shows that the choice of delivery location and maternal birth experience are influenced by economic, social, and structural factors. Economic constraints, including inability to afford hospital delivery and negative experiences with healthcare providers, discourage women from giving birth in hospitals. Social factors such as traditional cultural practices, low awareness of hospital procedures, and the educational level of women and their husbands affect health-seeking behavior and delivery decisions. Structural barriers, including heavy staff workload, resource shortages, limited healthcare facilities, and poor transportation especially in rural areas reduce the quality of care and increase home birth rates.

DISCUSSION

This scoping review summarized findings from 8 primary research articles conducted in lower middle-income countries, including Bangladesh, Eritrea, Ethiopia, Sierra Leone, Chiapas, Zambia and Kenya. Using a mix of qualitative and cross-sectional designs, the studies captured maternal perspectives on childbirth. The findings revealed that economic, social, and structural factors influence maternal birth experiences and delivery choices in LMICs. Key barriers included hospital costs and financial abuse within healthcare facilities, which were significant factors resulting in increased home births and fear of mistreatment. Moreover, lack of autonomy, poor facility infrastructure and limiting access to emergency care were identified (Smith et al., 2022; Bohren et al., 2015). Additionally, findings revealed a notable influence of informal payments on the selection of childbirth locations in lower-middle-income countries, an area underexplored in previous research (Treacy et al., 2018; Mayra et al., 2021). Together these factors contribute to the prevalent reliance on home births and traditional birth attendants. The following sections discuss how each of these themes influenced maternal experience and decision making.

Social factors such as cultural beliefs, education levels, and gender roles also shaped decisions regarding the delivery location. Couples with higher educational attainment were more open to modern medical practices, valued skilled birth attendants, and felt more comfortable with healthcare providers (Nahar et al., 2022). In patriarchal societies, the education level of the husband was particularly important in determining the delivery location. The higher the education level, the more likely it is for births to occur in health facilities. (Kifle et al., 2018; Nahar et al., 2022; Treacy et al., 2018).

The influence of the husband importantly reflects the woman's lowered autonomy, in that where she gives birth is not solely her choice alone. Reduced autonomy may in itself affect maternal birth experience, as the decision of delivery location was likely made by multiple individuals. Moreover, cultural preferences and fear of hospital delivery procedures due to lack of awareness were noted as crucial factors in promoting home births (Nahar et al., 2022; Roro et al., 2014). Familiarity with providers, common culture and language improved maternal birth experience (Aranda et al., 2024; Srivastava et al., 2015; Colombara et al., 2016) Structural issues, including staff shortages,

poor infrastructure, lack of privacy, transportation challenges and limited access to healthcare facilities in rural areas further undermine facility-based care (Sialubanje et al., 2015; Islam et al., 2022; Straneo et al., 2024;Aranda et al., 2024; Srivastava et al., 2015; Sudhinaraset et al., 2023; Afaya et al., 2020). Women reported greater satisfaction with their experience in community health centres, where providers offered more personalized care and attention to each patient (Jha et al., 2017).

There has been previous work on this topic that supports the present findings. Bohren et al. (2014) published a bigger review including 34 papers from 17 different LMICs where they identified factors influencing delivery location. Similarly, they found factors such as familial influence, distance to the facility, cost of hospital birth and importantly, lower perceived quality of care in facilities as well as fear of discrimination and fear of undesirable procedures (Bohren et al., 2014). Relating to birth experience, the study mentions the belief held by women and their families that facility births medicalize and dehumanize the process (Bohren et al., 2014). The authors emphasize that there were abundant reports of abusive behaviour from obstetrical staff and call for respectful, high quality care as an important aspect of birth experience (Bohren et al., 2014).

While this study did not discuss the influence of education level, Gabrysch and Campbell (2009) demonstrate in their literature review of the East Africa region that education increased use of delivery facilities, along with household wealth and urban residence, which is consistent with our findings. As with the review by Bohren et al. (2014) and this present study, distance to health facilities decreased these births (Gabrysch and Campbell, 2009). Wealth, education and urban residence were also emphasized in a meta-analysis of demographic and health surveys in LMICs conducted by Hernández-Vásquez et al. in 2021. Overall, the findings of this study are consistent with previous publications and effectively combine factors to provide a comprehensive view of delivery experience in LMICs.

The research identified key factors influencing maternal birth experience in LMICs and emphasized the need for targeted interventions. Financial burdens, such as hospital and informal costs, significantly affected mothers' choices and birth experience. Social determinants such as mother's education levels, cultural beliefs and awareness of hospital procedures also shaped delivery preferences. Structural challenges, including shortages of staff and healthcare resources, as well as poor rural healthcare access, further hinder positive birth experiences. Addressing these barriers through affordable, culturally sensitive, and accessible healthcare, along with improved access to skilled birth attendants, and initiatives targeting educational gaps, may enhance the maternal birth experience. However, this review's notable limitation was that we relied on 2 databases, which may have limited the scope and diversity of the literature reviewed.

Additionally, we focused on contemporary cases, which is why we included only papers published in the last 10 years. However, this approach may have excluded important information published before 2014. Despite these limitations, the findings provide valuable insights to inform policy and interventions aimed at improving maternal care in LMICs.

AUTHORS CONTRIBUTION

Conceptualization: MP, SQ. Data Curation: MP, SQ, CN. Investigation: MP, SQ, CN.

Methodology: MP, SQ. Project Administration: MP. Resources: MP, SQ. Supervision: MP. Validation: MP, AL, AA. Visualization: MP, SQ. HAS. Writing – original draft preparation: MP, SQ, CN. Writing – review & editing: All authors. All authors agree to be accountable for all aspects of the work. All authors have read and agreed to the submitted version of the manuscript.

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CONFLICT OF INTEREST

There was no conflict of interest.

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