World Journal of Advanced Research and Reviews
eISSN: 2581-9615 CODEN (USA): WJARAI
Cross Ref DOI: 10.30574/wjarr
Journal homepage: https://wjarr.com/

(REVIEW ARTICLE)

Check for updates

Healthcare provider–primiparous woman relationship: Association with the quality of prenatal care at the Bernard Kouchner Maternal and Child Municipal Medical Center in Kaloum

Tiranké Touré [1, 2, *], Kèfing Condé [1, 2], Gilchrist Fabrice Gouthon [1, 2, 3], Raymond-Bernard Ahouandjinou [3] and Zainoul Traoré [1, 2]

[1] *Research Laboratory on Society, Democracy, and Sustainable Development (LASODED).*
[2] *Laboratory for Socio-Anthropological Analysis of Guinea (LASAG). General Lansana Conté University of Sonfonia–Conakry (UGLC-SC), Republic of Guinea.*
[3] *Center for Studies and Research in Education and Social Interventions for Development (CEREID). National Institute of Youth, Physical Education, and Sports. University of Abomey-Calavi, Porto-Novo, Republic of Benin.*

World Journal of Advanced Research and Reviews, 2026, 30(03), 2180-2187

Publication history: Received on 22 May 2026; revised on 27 June 2026; accepted on 30 June 2026

Article DOI: https://doi.org/10.30574/wjarr.2026.30.3.1797

Abstract

In the Republic of Guinea, maternal mortality remains alarmingly high due to serious shortcomings in the quality of prenatal care. This study aimed to analyze the quality of the relationship between healthcare providers and primiparous women during prenatal care at the Bernard Kouchner Community Mother and Child Medical Center in Kaloum, and to assess its impact on the quality of care provided. This was a qualitative cross-sectional study conducted among 23 primiparous women aged 18 to 28, 16 health care providers—including five doctors, four nurses, seven midwives, and four administrative staff members. The results revealed that the caregiver-primiparous woman relationship is generally perceived as caring and satisfactory, based on the caregiver's perceived technical competence, respectful communication, and availability. However, structural constraints such as service overload, language barriers, and sociocultural norms related to gender and marital authority limit the full effectiveness of this therapeutic relationship. These findings suggest the need to strengthen relational training for healthcare professionals, adapt communication strategies to the ethnolinguistic diversity of patients, and improve the organizational conditions of prenatal care to reduce maternal mortality and improve women's adherence to prenatal care in Guinea.

Keywords: Prenatal care; Trust; Gender relations; Communication; Conakry

1. Introduction

Women's health during pregnancy is a critical consideration, as it can have a significant impact on the mother (Audic et al., 2023), fetal development, and even the child's future life. Stressful situations—such as financial problems, family conflicts, a history of depression, and, above all, difficult interactions during medical appointments—can exacerbate health issues during this period. Pregnancy and childbirth remain high-risk periods for maternal and neonatal health (Ammar et al., 2026).

Approximately 830 women die every day from complications related to pregnancy or childbirth, 99% of them in developing countries (Alkassoum et al., 2018). In sub-Saharan Africa, maternal deaths accounted for 66% of the cases recorded worldwide in 2017 (Foumsou et al., 2018). In Guinea, the situation is particularly alarming, with maternal mortality estimated at 679 deaths per 100,000 live births in 2023 (UNICEF, 2023), compared to 576 in 2017 (Guinea DHS, 2018). These deaths reflect significant and profound weaknesses in the quality of prenatal care systems. Several

* Corresponding author: Tiranké Touré

factors account for this excess mortality (Bah et al., 2025; Madjita and Hélène, 2026). These include inadequate health infrastructure, low coverage of prenatal care, a shortage of qualified personnel, and, above all, compromised quality of care due to deficiencies in caregiver-patient interactions.

Despite the progress made over the years—with a 38% reduction in the maternal mortality ratio between 2000 and 2017 (a rate of 211 deaths per 100,000 live births)—the persistence of this level underscores the urgent need for action (WHO, 2019). The average annual reduction rate of 2.9% reflects the sustained efforts of governments and the effectiveness of public health interventions (WHO, 2019). In Conakry, in the Kaloum district, health facilities are facing growing demand amid high urban density.

The Bernard Kouchner Community Mother and Child Medical Center in Kaloum receives a large number of pregnant women every day. They are often first-time or multiparous mothers. Their care raises questions about the quality of care provided and, specifically, about the nature of interactions between healthcare providers and patients. There is a lack of adequate communication between healthcare providers and pregnant women—especially first-time mothers—within the Community Medical Center, which affects their use of services, their overall trust in the care provided, and their perception of the quality of care. However, a well-established patient-healthcare provider relationship forms the essential foundation of medical practice (Behe and Genty, 2024) and ensures that the patient is listened to and that their personal situation and treatment choices are taken into account (Bouthors et al., 2021; Guañabéns et al., 2025). It influences patient satisfaction, adherence to medical follow-up, and return visits. This relational dimension remains understudied in the Guinean context. The power dynamics observed in the patient-caregiver relationship have a significant effect on patients' autonomy, choices, and decisions (Masella and Godard, 2024).

Communication and the relationship that develops between pregnant women and healthcare professionals are now a key factor in improving maternal care (Hatem et al., 2018), particularly in prenatal settings where challenges remain numerous. Based on observations of attendance patterns and pregnancy outcomes—particularly among first-time mothers—at the Bernard Kouchner Mother and Child Health Center in Kaloum, effective communication is believed to improve prenatal care and reduce maternal mortality. The relevance of this research lies in assessing the relationship between healthcare providers and primiparous women in relation to the quality of care within a society deeply rooted in socioeconomic, cultural, and institutional inequalities. This study seeks to answer the following question: How does the quality of the relationship between healthcare providers and pregnant women influence the quality of prenatal care at the Bernard Kouchner Community Maternal and Child Health Center in Kaloum?

2. Methodological Approach

2.1. Population and Sampling

This is a qualitative cross-sectional study conducted in the city of Conakry at the Bernard Kouchner Mother and Child Health Center in Kaloum. This study collected non-numerical data, specifically the respondents' statements on the research topic. The target population consisted of 23 primiparous women aged 18 to 28, 16 health care workers—including five doctors, four nurses, seven midwives, and four administrative staff members.

The sample of 23 primiparous women aged 18 to 28 was selected using a non-random method with the convenience sampling technique, meaning that those encountered who were immediately available were interviewed. The study sample of health care workers (doctors, nurses, midwives) and administrative staff was selected using a non-random method with the volunteer technique, such that those who agreed to answer the questions were included in the sample.

2.2. Data Collection Tools and Techniques

Interviews with the participants were conducted using a specific interview guide tailored to each participant. The data collected focused on the caregiver-primiparous woman relationship and perceptions of communication during prenatal care. Cultural representations and the relationship between the caregiver and the pregnant woman were also documented. The interviews were conducted using a cell phone (Tecno Camon 50 Pro, Model CN5c) equipped with a voice recorder, with the respondents' consent. Data collection lasted 45 days, from April 23 to June 6, 2026, with the support of interpreters trained in the collection and management of qualitative data. Semi-structured interviews were conducted with the defined target group until saturation was reached.

2.3. Data Analysis

After transcription, the interviews—based on the items contained in the interview guide—were analyzed and then grouped by theme to compare the responses obtained with the research hypothesis. Responses that were more or less

identical were classified by area of interest. Indeed, after carefully listening to the interview recordings, units of meaning were identified in order to give substance to the themes and subthemes that emerged from the interviews as a whole.

3. Results

The relationship between a primiparous woman and her healthcare provider encompasses symbolic, emotional, and social dimensions; analyzing these dimensions provides a better understanding of the dynamics of seeking and adhering to care. It is therefore not limited to a mere technical interaction between a healthcare professional and a patient. In the context of prenatal care, the focus is on primiparous women within this relationship. This relationship is of particular importance because first-time mothers are experiencing their first pregnancy and find themselves in a situation of discovery and physiological, psychological, and social vulnerability. Based on the communication between first-time mothers and healthcare providers, it is recognized that the dynamics of active listening and counseling are critical to the quality of their prenatal care.

All the women surveyed expressed overall satisfaction with the attitude of the healthcare staff toward them. Their comments point to a common perception: that of a warm welcome, attentive care, and a conflict-free relationship. In line with this, one first-time mother stated:

> They're taking good care of me, and I'm happy, since this is my first pregnancy (A. K., age 20; first-time mother; April 2026).

In a similar vein, another respondent linked the quality of a caregiver's attitude to professional competence. She stated the following:

> They do a great job; they're very good at what they do, and they take good care of me. That's what I think (A. S. S., age 22; first-time mother; June 2026).

These findings are consistent with the view expressed by health care workers, who believe that the quality of care depends on the ability to welcome patients, reassure them, and create an environment conducive to open communication. One of the health care workers explains:

> When a patient comes here—for example, there was a woman who came in this morning. I took very good care of her. I made her feel very welcome, and we pampered her right up until she gave birth (B. H., 38; Midwife; June 2026).

This statement goes beyond the technical aspects of care, incorporating the relational and emotional dimensions as well. Similarly, a doctor interviewed about this issue—specifically, the attitudes toward first-time mothers—said:

> First, you have to put the patient at ease. When you put the patient at ease by making her feel comfortable with the doctor and nurse, when you create that sense of comfort, the patient will feel better and be able to listen more attentively to what you have to say (M. J., 33, Doctor; May 2026).

This perspective aligns with the statements of the first-time mothers surveyed, as they acknowledge that this subjective sense of care depends as much on the attentiveness and respect they receive as on the provision of medical care. However, a nuance emerges in the accounts of some first-time mothers which, beyond their satisfaction, reveals organizational limitations that may affect their experience regarding the quality of care at the Community Health Center. A confusion thus arises between technical expertise and interpersonal skills. For these women, receiving good care also means being treated well; these two dimensions are inseparable in the construction of their personal experience of healthcare. As evidence, one woman states:

> When you come in for the ultrasound, I'm not going to blame them—how should I put it?—because it takes time, and also because it's so crowded; there are so many people here, especially on Mondays, Tuesdays, and Thursdays. When you come—no, you won't even have a place to sit; it's the doctor's fault—he's on his own… Doing an ultrasound is going to take time… it could take all day (M. B., age 26; first-time mother; May 2026)

The quality of the patient-provider relationship can therefore coexist with structural constraints in health care services. The relationship with prenatal care is shaped by both relational and organizational factors, which are influenced by the workload and the operations of the Bernard Kouchner Community Mother and Child Medical Center in Kaloum.

During the surveys, the emotional experiences of first-time mothers during prenatal visits were discussed. For many women, their first pregnancy is a completely new experience, marked by a certain emotional vulnerability. When asked about any discomfort, fear, or humiliation they might have felt during prenatal visits, first-time mothers described nuanced experiences ranging from rapid reassurance to initial apprehension stemming from the unknown. The majority of women surveyed stated that they did not feel humiliated or afraid in their interactions with healthcare providers. One of them said:

This is my first pregnancy here, but I've heard that everything goes smoothly here, so I'm not afraid (A. B., age 20; first-time mother; April 2026)

This verbatim account reflects a mechanism of social reassurance, conveyed by those around her, which positively influences the woman's experience even before her first contact with the healthcare provider. However, an important nuance is noted in an interview with a first-time mother. She shared the following:

Well, yeah, my first time—because it was the first time we'd met, so I didn't know how she'd react to me or even how she'd talk sometimes; I had my doubts. It was actually my husband who was pushing me… She's told me now that she's available, and every time since then, she's been the one giving me the courage by calling me (F. B., 20 years old; first-time mother; June 2026).

The emotional experience of first-time mothers is generally positive at this facility. The quality of the initial welcome and the availability of healthcare providers appear to be key factors in the relationship between healthcare providers and first-time mothers.

In the context of prenatal care, trust is the foundation of any therapeutic relationship. It takes on a special significance because it is built within a relationship that is both intimate and institutional. One respondent shared:

I trust all of them. Oh, and no one has ever spoken to me rudely here since I arrived (D. F., 25 years old; first-time mother; June 2026).

Another respondent went on to state that:

She's friendly… she plays with everyone (A. S., 28 years old; first-time mother; June 2026).

Trust is directly linked to respect in communication. Women evaluate their healthcare providers based on competence and respect. A healthcare provider's availability, warmth, and approachability are criteria for trust just as much as clinical competence. Interpersonal skills are therefore important in building the therapeutic relationship. Regarding the issue of trust in healthcare providers, some interviews revealed a conflict between personal preference and marital pressure. A first-time mother explained this as follows:

I just hated women… I'm with a woman because that's what my husband wants; he doesn't want a man to see his wife (F. S., age 26; first-time mother; April 2026).

The gender of the healthcare provider is a factor in trust (or mistrust) influenced not only by the patient's personal perceptions but also by societal and community norms. Women do not freely choose their healthcare provider, which raises the question of the autonomy of first-time mothers in the context of prenatal care.

Furthermore, healthcare providers are aware that their relationship with first-time mothers—through effective communication—influences the quality of care and directly impacts these women's well-being. It is in this vein that one physician stated:

Effective communication means making her understand that she is pregnant and that she needs to take care of herself (A. A., age 40; Obstetrician-Gynecologist; May 2026).

First-time mothers' trust in their healthcare providers is thus based on three key elements: competence, respect, and availability. In addition, another important aspect was highlighted during the discussions: first-time mothers' access to information and their ability to express themselves. The ability of a first-time mother to ask her healthcare provider questions, seek clarification, and actively participate in her care remains a key indicator of the quality of the caregiver-patient relationship.

The majority of first-time mothers surveyed reported that they ask their healthcare providers for clarification. One of the respondents stated:

> Yes, if they speak—even if I didn't understand—I'll just ask them, and then they'll explain it to me (B. B., 22 years old; first-time mother; May 2026).

Another person echoes these sentiments, saying that:

> Whenever there's something I don't understand, as soon as I ask, she tells me, "Do this, do that"—like, how I'm supposed to behave. She's often told me, and has continued to do so up to now, to exercise and move my body, but without bending over (D. A., 22 years old; first-time mother; June 2026).

For healthcare workers, there are concerns regarding the needs expressed by women. On this subject, a doctor explained:

> Consultations take place in a private setting so that the patient can open up… it's also important to understand the dialect the patient speaks (D. A., age 35; Physician; June 2026).

The issue of confidentiality and the language barrier was highlighted in this verbatim transcript. In Guinea, where there is significant ethnolinguistic diversity, a mismatch between the language spoken by the healthcare provider and that of the patient can pose a major obstacle to effective communication. A midwife provided further clarification during the interviews.

> It is we midwives who can help pregnant women understand what is known as prenatal care. It is through us that pregnant women can receive prenatal care without any problems (D. A., age 32; Midwife; June 2026).

The relationship between healthcare providers and first-time mothers during prenatal care at the CMC-MEBK in Kaloum appears, on the whole, to be functional and supportive, from the perspective of both the first-time mothers and the healthcare providers. The women feel free to ask their healthcare providers questions, and the healthcare workers are aware of their educational role. Nevertheless, disparities persist in how healthcare providers approach communication. Obstacles related to language barriers and confidentiality must be addressed to ensure a higher quality of care for all women, particularly first-time mothers.

4. Analyse

4.1. A predominantly positive emotional experience, with no reported abuse

The results of this study indicate that, overall, the primiparous women surveyed did not report experiencing verbal abuse from healthcare providers. Studies have revealed attitudes of contempt and impatience on the part of healthcare providers toward pregnant women with low levels of education or who are economically disadvantaged (Gentile et al., 2025; Jacobsson et al., 2025; Kasaye et al., 2023). The fact that the respondents did not report such experiences can be explained by several hypotheses. It is possible that the quality of care at the Kaloum MCHC is slightly above the regional average. Additionally, social desirability bias may be at play. Some first-time mothers still receiving care at the medical center may be reluctant to voice negative criticism of their healthcare providers (Tremblay and Berthelot, 2024), either out of fear of retaliation or out of gratitude toward the professionals on whom they still depend.

4.2. The foundations of trust: a multidimensional construct influenced by cultural and marital factors

The results revealed that first-time mothers' trust in their healthcare providers rests on three pillars: perceived technical competence, respectful communication, and the provider's availability. Research has shown that the patient-physician relationship is based on several dimensions that constitute trust: technical competence, benevolence, honesty, confidentiality, and advocacy for the patient's interests (Derbez, 2023; Isseki and Brasseur, 2024). The data collected confirmed the competence and benevolence highlighted in the statements of first-time mothers. The respectful attitude of healthcare providers is the main predictor of women's satisfaction with the care they receive, ranking even higher than the technical quality of care (Diallo, 2022; Diarra, 2025). The availability and responsiveness of healthcare providers are key foundations for trust and adherence to prenatal care.

Furthermore, the role of gender norms and marital authority in access to prenatal care was revealed during the interviews. This reality has been documented in several studies (Diallo, 2022; Guindo et al., 2023; Kane et al., 2022;

Madjita et al., 2026; Pierre et al., 2025; Philibert et al., 2023). In this regard, one study showed that patriarchal norms significantly influence the use of healthcare services and the choice of healthcare provider in Guinea (Diallo, 2022). Mistrust of midwives reveals the existence of hierarchical professional perceptions within the health care system itself, where doctors enjoy a higher social status than midwives.

4.3. The relationship between healthcare provider and first-time mother and the quality of care: communication as a key factor

All the women interviewed reported that they felt comfortable asking their caregivers questions and receiving satisfactory answers. This finding is significant in a context where the caregiver holds the knowledge and the patient is expected to comply without questioning. A patient's ability to ask her healthcare provider questions is strongly associated with the sense of security she feels in the relationship (Berghmans, 2026; Thomas and Hazif-Thomas, 2022), as well as with her level of education and her understanding of medical consultation ethics (Le CCNE, 2023).

In the sample of this study, the language barrier was identified by healthcare providers as a structural obstacle to communication with first-time mothers in the Guinean context. Furthermore, the language barrier has been identified as one of the main obstacles to attending prenatal checkups among women in rural and peri-urban areas (Bagalwa et al., 2025).

5. Conclusion

The positive experience reported by first-time mothers in this study is an encouraging finding, but one that must be interpreted with caution, particularly due to the social desirability bias inherent in interviews conducted in medical centers. First-time mothers' trust in their healthcare providers is a multidimensional construct, influenced by both individual factors (perceived competence, quality of communication) and sociocultural determinants (the healthcare provider's gender, marital authority, and hierarchical professional roles). These dimensions, which are integral to medical practice, must be taken into account in the training of healthcare professionals and in the design of prenatal care policies.

Furthermore, the quality of care in the caregiver–primiparous woman relationship at the CMC-MEBK in Kaloum was discussed at length. This supportive relationship, however, faces persistent structural constraints: overburdened services, language barriers, and insufficient confidentiality during consultations. Although these obstacles do not systematically compromise the relationship between healthcare providers and first-time mothers, they do limit its effectiveness. Improving the quality of prenatal care cannot be reduced solely to the relational dimension; it also requires an organizational and institutional response adapted to the Guinean context. Ultimately, strengthening the relationship between healthcare providers and first-time mothers, while respecting their autonomy and cultural diversity, is an essential foundation for improving the quality of care and ensuring proper prenatal follow-up. These strategies will help reduce maternal and infant mortality in health centers.

Compliance with ethical standards

Acknowledgments

The authors are extremely grateful to all the primiparous women, healthcare workers, and administrative staff at the Bernard Kouchner Community Maternal and Child Health Center in Kaloum who participated in this study.

Disclosure of conflict of interest

The authors declare no conflicts of interest.

References

[1] Kane, H., Coulibaly, A., Hane, F., & Doudou, D. T. (2022). Les agents de santé communautaire, maillon du biopouvoir: des normes sanitaires aux normes de genre. Biopolitique en Afrique de l'Ouest. Monde de vie, santé, populations.

[2] Philibert, L., Osomba, A. N., Lapierre, J., Kiki, G. M., Ngangue, P., Thomas, R., ... & Ntanda, G. M. (2023). Comprendre les dimensions d'influence du recours tardif et du non-respect des normes en consultation prénatale chez les adolescentes enceintes à Haïti: une étude qualitative. Sexologies, 32(2), 160-169.

[3] Guindo, M. M. A., Kone, H., & Mburano, R. (2023). Recours aux soins prénatals au Mali: Une analyse de la qualité des soins. ESI Preprints (European Scientific Journal, ESJ), 16, 301-301.

[4] Pierre, A., Bithorel, P. L., & Solotareff, R. (2025). Dépenses de santé et recours aux soins des hommes et des femmes-Différences et effets de genre. médecine/sciences, 41(12), 1046-1053.

[5] Madjita, N., & Helene, K. K. (2026). Facteurs psychosociaux du recours à l'accouchement assiste par du personnel qualifie en milieu médical dans la ville de Moundou au Tchad. International Journal of Innovation and Applied Studies, 48(1), 194-212.

[6] Thomas, P., & Hazif-Thomas, C. (2022). L'empathie et le sens de la relation dans le soin. NPG Neurologie-Psychiatrie-Gériatrie, 22(128), 72-81.

[7] Berghmans, C. (2026). L'efficacité perçue des barreurs de feu dans le processus de soins: une approche clinique et sociale. L'Évolution Psychiatrique.

[8] Le CCNE, (2023). Intimité et relation de soin Consentement et respect de la personne dans la pratique des examens gynécologiques ou touchant à l'intimité. Les Dossiers de l'obstétrique - Sage-femme, 532-533(3), 32-43. https://doi.org/10.54695/dosf.532.0032.

[9] Masella, M. A., & Godard, B. (2024). L'empowerment en santé reproductive: vers une visée éthique des soins. Éthique publique. Revue internationale d'éthique sociétale et gouvernementale, 26(1).

[10] Audic, M., Paul, A., Letot, J., & Wendland, J. (2023). Représentations maternelles et attachement prénatal chez des femmes enceintes ayant des complications de la grossesse. Périnatalité, 15(1), 33-43.

[11] Ammar, L. B., Elouafa, J., & Hamraoui, M. (2026). Perte périnatale post-interruption volontaire de grossesse et croyance en la punition divine: impact sur l'investissement du futur enfant et mobilisation des croyances culturelles. Revue Internationale de la Recherche Scientifique et de l'Innovation (Revue-IRSI), 4(2), 608-621.

[12] Compaoré, A & Bado, A. R. (2026). Facteurs associés aux soins prénatals incomplets: Analyse comparative multiniveau des données des enquêtes démographiques et de santé du Burkina Faso et du Mali. Revue Africaine des Sciences Sociales et de la Santé Publique, 8(1), 383-403.

[13] Madjita, N., & Helene, K. K. (2026). Facteurs psychosociaux du recours à l'accouchement assiste par du personnel qualifie en milieu médical dans la ville de Moundou au Tchad. International Journal of Innovation and Applied Studies, 48(1), 194-212.

[14] Bah, I. K., Diallo, M. C., Bah, E. M., Barry, A. Y., Diallo, I. G., & Sy, T. (2025). Prise en charge et pronostic du mauvais suivi prénatal à la maternité du CHU Ignace Deen, Guinée. Annales de la SOGGO, 20(44), 11-16.

[15] Behe, L., & Genty, N. (2024). Dire son accouchement et le rapport au personnel soignant: savoir, confiance et obéissance. Langue française, 223(3), 79-96.

[16] Bouthors, A. S., Duverger, C., Bensoussan, H., Vérité, E., Subtil, D., & Morau, E. (2021). Comment améliorer le bien-être maternel?. Le Praticien en Anesthésie Réanimation, 25(2), 92-97.

[17] Guañabéns, C. D. O., Brandi, L. F. D. C., Andrade, P. M. B. D., Bernardino, E., & Souza, K. V. D. (2025). Soins infirmiers obstétricaux et pratiques intégratives: perspectives de la pratique avancée dans le SUS. Acta Paulista de Enfermagem, 38, e-SPE22p.

[18] Masella, M. A., & Godard, B. (2024). L'empowerment en santé reproductive: vers une visée éthique des soins. Éthique publique. Revue internationale d'éthique sociétale et gouvernementale, 26(1).

[19] Hatem, M., Halabi-Nassif, H., & Maroun, M. (2018). Évaluation de la qualité des services de santé maternelle et néonatale en Guinée-Conakry et au Togo. Santé publique, (HS), 101-111.

[20] Kasaye, H., Sheehy, A., Scarf, V., & Baird, K. (2023). The roles of multi-component interventions in reducing mistreatment of women and enhancing respectful maternity care: a systematic review. BMC Pregnancy and Childbirth, 23(1), 305.

[21] Jacobsson, B., Requejo, J. H., Dey, T., Lavin, T., Mannah, M. T., Menon, R., ... & Vogel, J. P. (2025). Women's health and maternal care services: seizing missed opportunities to prevent and manage preterm birth. Reproductive health, 22(Suppl 2), 109.

[22] Gentile, L., & Jullien, C. (2025). Humilier pour soigner? Violences structurelles et violences pragmatiques dans des maternités indiennes. Genèses, 138(1), 37-58.

[23] Tremblay, M. J., & Berthelot, N. (2024). Les effets d'une intervention basée sur la pleine conscience sur le bien-être des femmes enceintes, l'adaptation à la parentalité et le développement des enfants: Une étude périnatale et longitudinale. Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, 56(4), 399.

[24] Isseki, B., & Brasseur, M. (2024). Les leviers managériaux de la confiance patient-médecin dans les établissements de santé. Recherches en Sciences de Gestion, 160(1), 117-142.

[25] Derbez, B. (2023). La vertu des sciences sociales à l'épreuve des comités d'éthique de la recherche en santé. Cahiers Droit, Sciences & Technologies, (16), 43-61.

[26] Diallo, A. (2022). Satisfaction des patientes prises en charge pour une urgence obstétricale dans une maternité de niveau II en Guinee. (Maternité du Centre Medical Communal de Ratoma a Conakry). Journal de la Sago (Gynécologie–Obstétrique et Santé de la Reproduction), 23(1).

[27] Diarra, D. (2025). Perception communautaire de la qualité des soins au Centre de Santé de Communautaire de Sirakoroba, Mali. Revue Internationale de la Recherche Scientifique et de l'Innovation (Revue-IRSI), 3(3), 757-768.

[28] Bagalwa, F. B., Ngwamah, A. F. B., Mbungu, R. M., & Babintu, L. M. B. (2025). Utilisation des services de consultations prénatales dans la zone de santé de Kadutu, Sud-Kivu (République Démocratique du Congo): perception et attentes des gestantes. *Revue des Sciences de la Santé*, *4*(1), 79-88.