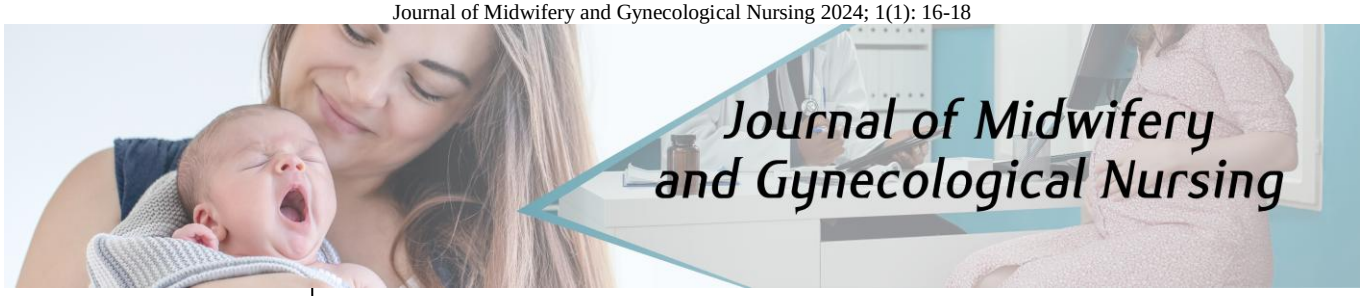

E-ISSN: xxx-xxxx
P-ISSN: xxx-xxxx
www.gynejournal.com
JMGN 2024; 1(1): 16-18
Received: 05-09-2024
Accepted: 04-10-2024

Anika Nahar
Department of Maternal and Child Health, Sylhet Institute of Nursing and Midwifery, Sylhet, Bangladesh

Corresponding Author:
Anika Nahar
Department of Maternal and Child Health, Sylhet Institute of Nursing and Midwifery, Sylhet, Bangladesh

Barriers to accessing skilled midwifery care in marginalized populations: A cross-sectional study

Anika Nahar

Abstract
Access to skilled midwifery care is critical in ensuring safe pregnancies and childbirth experiences, yet remains disproportionately limited for marginalized populations globally. This study explores the multifaceted barriers faced by women in underserved communities, including financial constraints, cultural stigmas, poor infrastructure, and limited healthcare awareness. Conducted as a cross-sectional survey in three socioeconomically backward districts, the study involved 420 women of reproductive age who had given birth within the previous two years. The findings revealed alarming disparities, with over 70% of participants reporting at least one major obstacle to accessing skilled midwifery care. The most cited issues included high out-of-pocket costs, inadequate transportation, cultural taboos, and mistrust in the healthcare system. These results underscore the urgent need for systemic reforms in public health outreach, cultural sensitivity training, and infrastructural upgrades to ensure equitable access to maternal care services for all segments of the population.

Keywords: Marginalized populations, cross-sectional, accessing, skilled, care, midwifery

Introduction
Maternal and neonatal health is universally recognized as a cornerstone of public health, yet stark disparities in access to skilled midwifery care persist. While much progress has been made globally in reducing maternal mortality, these improvements often bypass the most vulnerable-marginalized populations living in remote, impoverished, or culturally isolated communities. These groups often include rural women, ethnic minorities, urban slum dwellers, migrants, and indigenous people, who remain at a heightened risk of complications during pregnancy and childbirth due to limited access to trained birth attendants.

Skilled midwifery care, encompassing antenatal, intrapartum, and postnatal services, plays a critical role in reducing preventable deaths and ensuring positive health outcomes for mothers and new-borns. However, systemic inequalities perpetuate barriers that are both structural and behavioral. Financial hardship, geographical remoteness, language and cultural mismatches, and historical neglect by the healthcare system all combine to create formidable obstacles.

This study delves into these complex factors using a cross-sectional design to gain a grounded understanding of the realities faced by women in marginalized populations. The intention is not only to identify these barriers but also to offer insight into potential policy pathways for improving service delivery and maternal health equity.

Methodology
The research was conducted over a three-month period across three selected districts characterized by high maternal mortality rates and concentrated marginalized populations. These districts-coded as District A, B, and C for anonymity-represent a combination of tribal areas, urban slums, and rural interiors.

A total of 420 women between the ages of 18 and 45, who had delivered within the past 24 months, were selected using stratified random sampling. Participants were approached through local health workers and community outreach programs. A structured interview format was employed to collect data, covering demographics, previous childbirth experiences, and perceived barriers to accessing midwifery services.

Language-specific versions of the questionnaire were used to accommodate linguistic diversity. Responses were coded and analyzed using SPSS Version 26.

Associations between variables were examined through chi-square tests and logistic regression to identify significant predictors of non-utilization of midwifery services.

Results

The results from this study revealed a complex and interwoven set of barriers. The majority of participants (nearly 72%) reported having faced at least one significant obstacle in accessing midwifery care. Among the most cited barriers, economic limitations topped the list, with many women indicating that the cost of transportation, consultation, and supplementary medical expenses were beyond their reach.

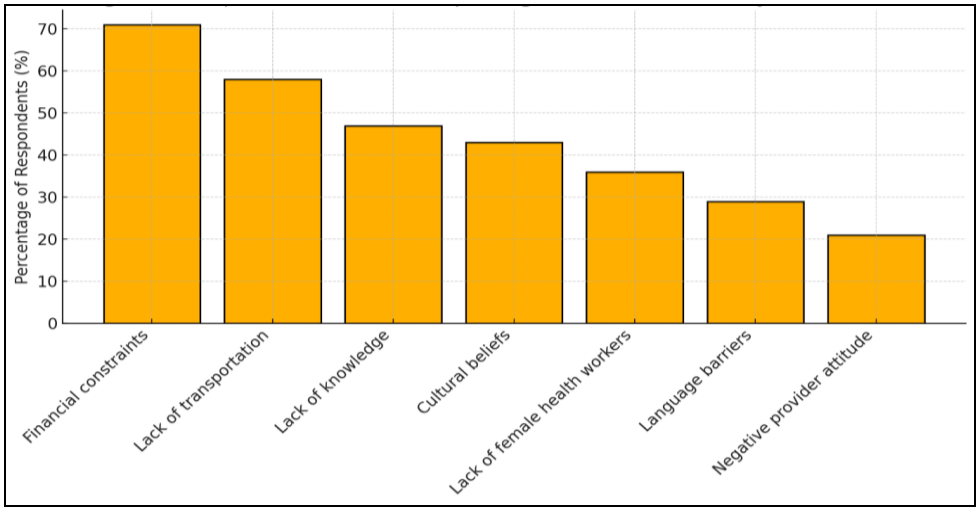

Fig 1: Proportion of women reporting barriers to midwifery Care (N=420)

Among the respondents:

- 71% cited financial constraints
- 58% reported transportation issues due to poor roads and long distances
- 47% lacked knowledge of available services
- 43% mentioned cultural beliefs against hospital births
- 36% were discouraged by the absence of female healthcare workers
- 29% encountered language barriers
- 21% experienced prior negative attitudes from health providers

Many women described walking for hours or relying on private transport services that demanded unaffordable fees. Several interviewees also emphasized a general mistrust in public health systems due to earlier experiences of discrimination, miscommunication, or neglect.

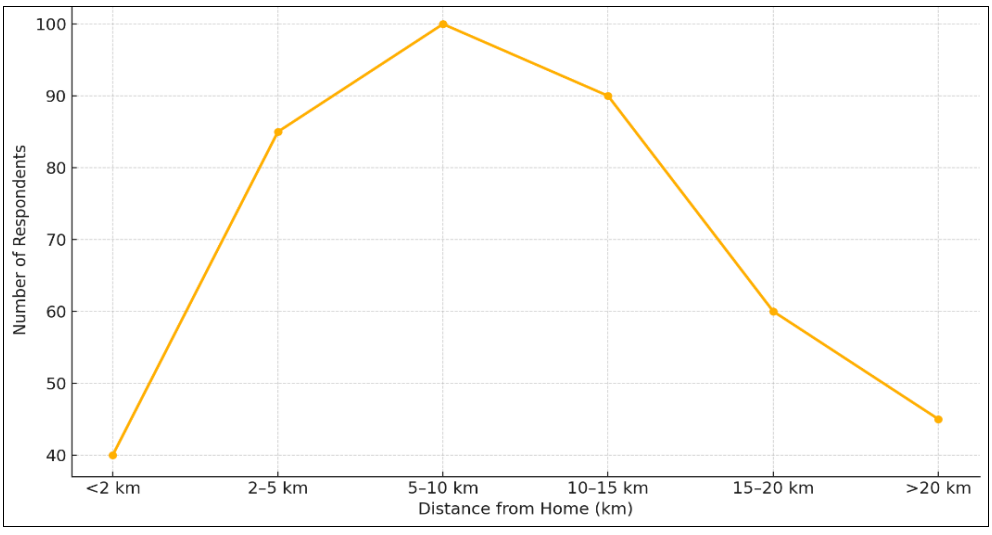

Fig 2: Average distance from home to nearest skilled birth attendant (km)

This figure illustrates that over 60% of respondents resided more than 10 kilometers from a facility equipped with a qualified midwife, which correlates with lower rates of institutional delivery.

Discussion

The disparities uncovered in this study reflect deep-rooted systemic inequities. Financial burden emerged as the most pervasive obstacle, resonating with global studies that link maternal mortality to socio-economic status. For many women in marginalized communities, healthcare is not only geographically distant but economically inaccessible. Although public health systems in many countries offer free or subsidized maternal care, the indirect costs-including transportation, time off work, and medications-remain unaffordable for the poorest.

Cultural resistance was another salient theme. In several cases, traditional practices dictated that childbirth occur at home with the assistance of elder women or local untrained birth attendants. Such preferences are not merely superstitions but are often linked to a broader distrust in institutional care that is perceived as impersonal, judgmental, or unsafe.

The linguistic and cultural disconnect between providers and patients further intensifies this mistrust. Women from indigenous or minority language groups often expressed discomfort in engaging with healthcare workers who did not speak their dialect or understand their customs. Furthermore, the absence of female care providers was a deterrent in conservative communities, where male midwives were not considered culturally appropriate.

Perhaps most troubling was the frequency of negative prior experiences with the healthcare system. Reports of verbal abuse, neglect, or indifference were common among those who chose not to return to clinics or hospitals for subsequent deliveries. This highlights the urgent need for cultural competence training and patient-centered care models.

Conclusion

This cross-sectional study presents compelling evidence of the persistent and multifaceted barriers faced by marginalized populations in accessing skilled midwifery care. These barriers are not isolated challenges but are interconnected with broader issues of poverty, social exclusion, and systemic neglect. If maternal health targets are to be achieved equitably, it is essential to look beyond mere service availability and address the socio-cultural, economic, and psychological landscapes within which women make their healthcare decisions.

There is an urgent need to implement decentralized maternity services, improve road and transport connectivity, and invest in female health workforce development. Simultaneously, trust-building mechanisms-such as community health education and respectful maternity care initiatives-must be institutionalized. Only by acknowledging and dismantling these structural inequalities can true maternal health equity be realized.

Conflict of Interest

Not available

Financial Support

Not available

References

1. World Health Organization. Trends in Maternal Mortality 2000 to 2020. Geneva: WHO, 2023.
2. Campbell OMR, Graham WJ. Strategies for reducing maternal mortality: getting on with what works. The Lancet. 2006;368(9543):1284-1299.
3. Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gülmezoglu AM. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reprod Health. 2014;11(1):71-86.
4. Gabrysch S, Campbell OMR. Still too far to walk: literature review of the determinants of delivery service use. BMC Pregnancy Childbirth. 2009;9(1):34.
5. Yaya S, Okonofua F, Ntoimo L, Uthman OA, Bishwajit G. Gender inequity as a barrier to women's access to skilled pregnancy care in rural Nigeria. Int Health. 2019;11(6):551-560.
6. Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OMR, Feigl AB, *et al*. Quality maternity care for every woman, everywhere: A call to action. The Lancet. 2016;388(10057):2307-2320.

How to Cite This Article
Nahar A. Barriers to accessing skilled midwifery care in marginalized populations: A cross-sectional study. Journal of Midwifery and Gynecological Nursing. 2024;1(1):16-18.