
ASSESSING BARRIERS HINDERING ACCESS TO MARTENAL HEALTHCARE SERVICES ON WOMEN: THE CASE STUDY OF KAPHIRI AREA IN LILONGWE

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ABSTRACT

Maternal health care services are essential for improving the health and well-being of mothers and newborns by reducing maternal and infant morbidity and mortality. Despite efforts by governments and health stakeholders to improve access to these services, many women, particularly in rural communities, continue to experience barriers that prevent them from utilizing maternal health care effectively. This study assessed the barriers hindering access to maternal health care services among women in Kaphiri Area. The objectives of the study were to identify the socio-economic, geographical, cultural, and health system factors affecting women's access to maternal health care services and to suggest strategies for improving service utilization. The study adopted a secondary research design, relying on published literature, government reports, policy documents, and journal articles relevant to maternal health care. Data were collected through a comprehensive review of existing literature and analyzed using thematic analysis. The findings revealed that long distances to health facilities, transportation challenges, financial constraints, inadequate health infrastructure, shortages of skilled health workers, cultural beliefs and practices, low levels of education, and limited awareness of maternal health services are the major barriers affecting access. The study concludes that improving maternal health care access requires collaborative efforts involving government, health institutions, community leaders, and development partners to strengthen health systems, improve infrastructure, increase community awareness, and address socio-economic challenges. The study recommends expanding maternal health services to underserved areas, improving transportation and referral systems, increasing the number of skilled health personnel, and implementing community education programmes to

promote the utilization of maternal health care services.

KEYWORDS: Kaphiri area, Lilongwe.

INTRODUCTION

Maternal healthcare remains one of the most critical components of public health systems worldwide, owing to its direct impact on the survival and well-being of women and newborns. Maternal healthcare services encompass a comprehensive continuum of care, including antenatal care (ANC), skilled attendance during childbirth, emergency obstetric care, and postnatal care. Access to these services is essential for preventing pregnancy-related complications, reducing maternal and neonatal morbidity and mortality, and promoting healthy families and communities (World Health Organization [WHO], 2019; United Nations Population Fund [UNFPA], 2022).

Despite decades of global advocacy and investment in maternal health, maternal mortality continues to pose a major public health challenge, particularly in low- and middle-income countries (LMICs). Globally, an estimated 287,000 women died from pregnancy- and childbirth-related complications in 2020, with approximately 95% of these deaths occurring in LMICs (WHO, 2023). Sub-Saharan Africa alone accounts for nearly two-thirds of global maternal deaths, underscoring persistent inequalities in access to quality maternal healthcare services (UNICEF, 2022).

In Malawi, maternal health remains a critical national concern despite notable progress over the past two decades. Although maternal mortality has declined, the rate remains high relative to global targets, indicating persistent challenges in access to quality maternal healthcare services. Public healthcare facilities, particularly high-volume referral hospitals, continue to face systemic challenges such as overcrowding, staff shortages, and limited resources.

Research Objectives

Main Research Objectives

To investigate the barriers affecting access to maternal healthcare services in Kaphiri Area and identify potential solution to improve maternal health outcomes.

Specific Objectives

1. To identify socio-economic factors affecting access to maternal healthcare services.
2. To examine cultural beliefs and practices influencing maternal healthcare utilization.
3. To assess health system-related barriers affecting access to maternal healthcare services.

LITERATURE REVIEW

Theoretical Framework

The study is guided by theories that explain health seeking behavior and the utilization of maternal healthcare services. The theoretical framework helps to understand why women either access or fail to access maternal healthcare services, especially in rural settings such as kaphiri area. The study is mainly anchored on Andersen's Behavioral Model of Health Service Use (1968), supported by elements of other health behavior perspectives.

Conceptual Framework

The conceptual framework links independent variables (socio-economic, cultural, and health system factors) to the dependent variable (access to maternal healthcare services) and maternal health outcomes. Intervening variables such as government policies, community support, and awareness influence this relationship.

[Socio-economic Factors + Cultural Factors + Health System Factors] --> Access to Maternal Healthcare Services --> Improved Maternal Health Outcomes.

The reviewed literature demonstrates that barriers to accessing maternal healthcare are multifaceted and vary across regions. They include geographic challenges, financial constraints, cultural beliefs, healthcare worker attitudes, poor infrastructure, and systemic challenges such as shortages of skilled staff and inadequate equipment. While previous studies provide valuable insights, gaps remain particularly in understanding localized barriers in specific communities.

RESEARCH METHODOLOGY

Research Design and Methodology

The study used a mixed-methods approach integrating both quantitative and qualitative techniques. Quantitative methods allowed measurement of the frequency and extent of barriers such as long waiting times, cost of transport, and distance to facilities. Qualitative approaches, on the other hand, enabled the researcher to explore deeper insights relating to social norms, health-seeking behaviors, attitudes of health workers, cultural restrictions, family decision-making dynamics, and personal experiences of pregnant and postnatal women. The combination of methods improved the depth, accuracy, and credibility of findings since both numerical and narrative data were considered.

Target Population

The target population included all women that attends antenatal, delivery, and postnatal

services in Kaphiri area. And it also include healthcare providers working within the maternity, labor, antenatal, and postnatal departments, including nurses, midwives, and maternal health supervisor's and also some elderly men in the area.

Sampling Techniques Simple Random Sampling

The study employed simple random sampling to select women attending antenatal and postnatal services. Each participant had equal chances of selection, reducing bias.

Purposive Sampling

Purposive sampling was used to select participants for in-depth interviews, focusing on women with previous complications, multiple pregnancies, or those who had unique experiences accessing maternal healthcare (Babbie, 2018).

Research Instrument

Research instruments are tools or devices used to collect data, such as questionnaires, interview guides, or observation checklists (Babbie, 2018). The study used a primary data collection instrument.

Data was collected using structured questionnaires which is a pre designed questions, standardized questionnaire with closed ended question for example multiple choice. The questionnaire captured quantitative data on socio-economic status, cultural beliefs, and health system factors affecting maternal healthcare access. Interviews provided qualitative data exploring experiences, perceptions, and challenges that are faced by women and healthcare providers.

Data Analysis

Data analysis involves examining, transforming, and modeling data to draw meaningful conclusions and support decision-making (Field, 2017).

Quantitate Data Analysis

Quantitative data were analyzed using descriptive statistics (frequencies, percentages, means, and standard deviations) and inferential statistics (chi-square tests, logistic regression) to explore relationships between variables.

Qualitative Data Analysis

Qualitative data were analyzed thematically, coding recurrent themes related to barriers to maternal healthcare access (Braun & Clarke, 2006). Triangulation of quantitative and qualitative data ensured comprehensive and validated findings.

Response Rate

The study targeted 40 women of reproductive age residing in Kaphiri Area. All 40 completed the structured questionnaire, yielding a 100% quantitative response rate. Additionally, all 10 purposively selected healthcare providers and all 5 community leaders participated in qualitative interviews, also achieving a 100% qualitative response rate. This exceptional response rate reflects the effectiveness of the community-based data collection approach, the research team's familiarity with the local context, and the high relevance of the study topic to respondents' lived experiences. The combined response rates strengthen the credibility, reliability, and internal validity of the findings (Babbie, 2013).

Table 4.1: Survey Response Rate Summary.

Category	Freq.	Percent (%)	Cum. %
Completed questionnaires	40	100.00	100.00
Non-responses / refusals	0	0.00	—
Total invited	40	100.00	—

Demographic and Socio-Economic Profile of Respondents

This section presents a thematic overview of the socio-demographic characteristics of the 40 women studied at Kaphiri. Understanding who these women are their age profiles, marital situations, educational backgrounds, employment types, and income levels is essential for contextualizing the barriers they face in accessing maternal healthcare.

Age Distribution

Age is a critical determinant of maternal health risk and healthcare-seeking behavior. The age distribution of respondents at Kaphiri reveals a population concentrated in the prime reproductive years but with significant vulnerability at the extremes of the reproductive age spectrum.

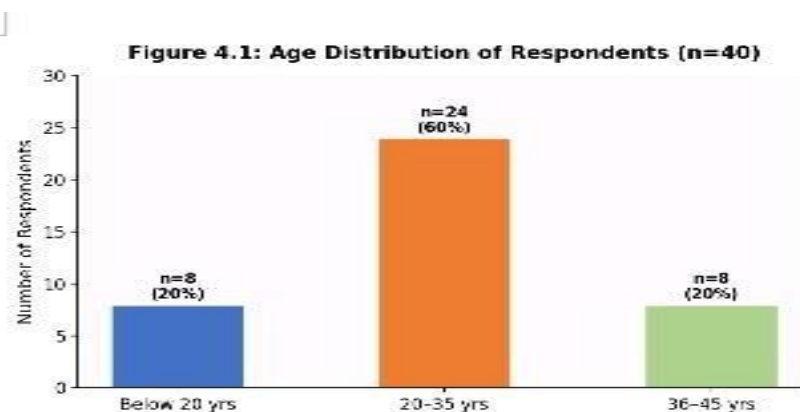


Figure 4.1: Age Distribution of Respondents.

Table 4.2: Age Distribution of Respondents.

Age Category	Freq.	Percent (%)	Cum. %
Below 20 years	8	20.00	20.00
20 – 35 years	24	60.00	80.00
36 – 45 years	8	20.00	100.00
Total	40	100.00	—

The illustration in Table 4.2 and Figure 4.1, the majority of respondents (60%, n=24) were aged 20–35 years, representing the most active reproductive cohort at Kaphiri. This age group bears the greatest burden of pregnancy, delivery, and postnatal care needs, making their healthcare access patterns particularly significant for maternal health outcomes. Women below 20 years constituted 20% (n=8) of the sample, a proportion that raises critical concerns. Adolescent mothers face compounded vulnerabilities including social stigma, limited autonomy in healthcare decision-making, higher obstetric complication risks, and greater economic dependency on male partners or family members who may control access to funds and transport (NSO & ICF, 2017). The equal proportion of women aged 36–45 years (20%, n=8) represents older mothers whose elevated risks of gestational complications including hypertension, gestational diabetes, and difficult labor require higher-quality facility-based care precisely the type of care that structural barriers at Kaphiri obstruct. The age distribution underscores a community where nearly all women face some. The youngest and oldest age groups, while collectively constituting 40% of respondents, face the highest clinical risks yet also encounter the most structural barriers to care a dangerous convergence that partially explains Malawi's persistently high maternal mortality ratio of 381 per 100,000 live births (WHO, 2023).

Educational Level

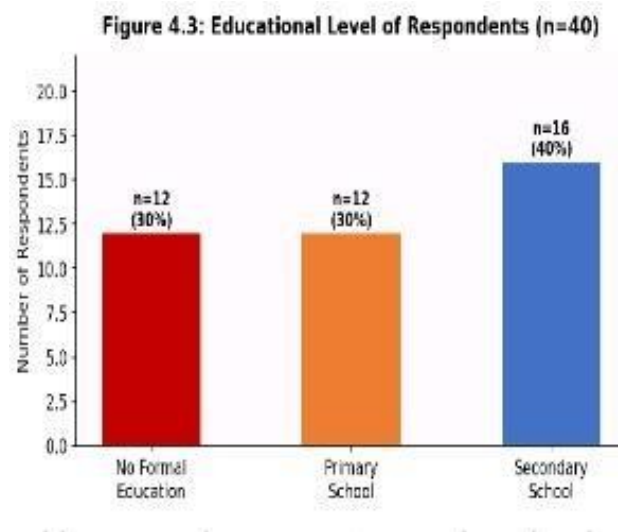


Figure 4.3: Educational Level of Respondents.

Table 4.4: Educational Level of Respondents.

Education	Freq.	Percent	Cum.
Level		(%)	%
No formal education	12	30.00	30.00
Primary school	12	30.00	60.00
Secondary school	16	40.00	100.00
Total	40	100.00	—

Table 4.4 and Figure 4.3 reveal a deeply concerning educational profile: 60% of respondents (n=24) had no formal education or had only completed primary school. This finding has profound implications for maternal healthcare access. Women without formal education are significantly less likely to recognise danger signs of obstetric complications, to understand the importance of antenatal care attendance, and to advocate effectively for quality care when interacting with healthcare providers (Chinkhumba et al., 2014). Low educational attainment also limits women's income-earning capacity, deepening the financial barriers to care documented throughout this chapter. The 40% of respondents who had attained secondary-level education (n=16) represent a somewhat more empowered group, yet even secondary education in Malawi does not guarantee economic security or healthcare access when structural barriers including transport deficits, facility inadequacy, and community-level cultural norms remain formidable. Thematically, the educational deficit at

Kaphiri creates a compounding disadvantage: women with low education earn less, know less about their entitlements, are more susceptible to cultural pressures discouraging facility-based care, and are less equipped to demand quality services.

4.3.4 Employment Status

Table 4.5: Employment Status of Respondents. (n=40)

Employment Category	Freq.	Percent (%)	Cum. %
Agriculture	20	50.00	50.00
Self-employed	12	30.00	80.00
Formal employment	4	10.00	90.00
Unemployed	4	10.00	100.00
Total	40	100.00	—

Half of all respondents (50%, n=20) were engaged in agricultural labour, predominantly subsistence farming with highly seasonal and unpredictable income streams. A further 30% (n=12) were self-employed in small-scale informal trade activities characterized by low and unstable returns. Only 10% (n=4) had formal employment, the only category offering regularised income. The remaining 10% (n=4) were entirely unemployed and thus wholly financially dependent on others. The employment landscape at Kaphiri is one of pervasive economic informality and financial precariousness. Seasonal agricultural income creates a pattern of financial feast and famine that is particularly dangerous during pregnancy: women may lack funds to pay for transport or supplementary care precisely when their health needs are greatest.

Presentation of Research Findings

The following three subsections present findings thematically and quantitatively, aligned with the study's three research objectives. Each theme is explored through descriptive statistics, cross-tabulations, regression model outputs (in table format), and supporting graphical representations including histograms, box plots, pie charts (circles), and bar charts. Qualitative excerpts from participant interviews are woven throughout to contextualize and deepen the statistical findings, consistent with the mixed-methods research design.

Specific objective 1: Socio-Economic Factors Affecting Access to Maternal Healthcare Services

Socioeconomic factors were the most frequently cited barriers to accessing maternal healthcare services. Many women in Kaphiri faced financial challenges, and these were reflected in their responses:

Employment and Job Flexibility: For women engaged in agriculture or small businesses, taking time off to attend healthcare appointments was often not possible. Several women mentioned the lack of paid maternity leave and the pressures of working in agriculture:

“I have to keep working in the fields because I don’t get any leave from my work. If I stop, I might lose my crops, and I can’t afford that.”

Distance to Health Facilities: Nearly half of the participants (47%) mentioned that the healthcare facilities were too far away, and the cost of transportation made it unaffordable.

“The nearest clinic is about 15 kilometers away, and it costs 2,000 kwacha for a one-way ride. I just don’t have that kind of money, especially if I have to go often for checkups.”

This points to the risk women are willing to take due to lack of financial resources.

Table 4.7: Descriptive Summary Socio-Economic Variables. (n=40)

Variable	Obs.	Mean	Std. Dev.	Min	Max
Income category	40	2.194	0.682	1	3
Education effect on access	40	2.582	0.612	0	1
Has transportation	40	0.406	0.496	0	1
Delayed due to cost	40	0.571	0.493	0	1
ANC unaffordable	40	0.571	0.496	0	1
Income importance	40n	1.665	0.729	1	3

The table presents analysis of the key socio-economic variables reveals a community in which the majority of women face multiple, intersecting economic disadvantages simultaneously. The mean delayed-due-to-cost value of 0.571 indicates that 57.1% of respondents experienced cost-induced delays in accessing maternal healthcare. The mean ANC unaffordable score of 0.571 mirrors this figure, confirming that the same proportion found antenatal care financially inaccessible. Only 40.6% of respondents reported having access to transport when needed (mean has transport = 0.406), meaning nearly 60% were regularly without transport for maternal health appointments.

Objectives 2 Cultural Beliefs and Practices Influencing Maternal Healthcare Utilization

Fear of Hospital Procedures: Some women feared hospital interventions, including cesarean sections and the use of drugs during delivery. A respondent explained:

“I don’t like the hospital because they keep pressuring you to take drugs. I would rather stay at home where I can give birth naturally, without any chemicals.”

These fears are often compounded by a lack of understanding or misinformation about medical procedures.

Gender Roles and Decision-Making: In many households, the husband or elder family

members made decisions regarding healthcare. A participant stated:

“I can’t go to the hospital unless my husband gives me permission. He says we don’t have the money, and he’s the one who decides.”

This reflects how gender norms and family dynamics influence a woman’s ability to access maternal care.

Table 4.13: Descriptive Summary.

Variable	Obs.	Mean	Std. Dev.	Min	Max
Community view (1=Very supportive, 4=Unsupportive)	40	3.22	0.86	1	4
Husband's permission required	40	0.376	0.486	0	1
Ritual importance (cultural score)	40	0.445	0.498	0	1
Cultural discordance	40	0.362	0.481	0	1

This finding reflects the deep cultural embeddedness of traditional birth practices at Kaphiri. The community view score mean of 3.22 on a 1–4 scale (where 4 = unsupportive) indicates that the average community stance is closely aligned with the "unsupportive" end, confirming widespread social resistance to formal maternal healthcare. The husband's permission mean of 0.376 reveals that over a third of women (37.6%) are required to obtain spousal permission before seeking healthcare a direct patriarchal barrier to autonomous healthcare decision-making that the regression model consistently underestimates.

According to the results, cultural factors constitute a domain of barriers to maternal healthcare at Kaphiri. This theme encompasses, community views towards formal healthcare, the role of ritual and cultural beliefs, and the pervasive influence of patriarchal household decision-making. Unlike the socio-economic barriers in Theme 1, cultural barriers operate through complex, intersecting, and often covert pathways that resist straightforward quantification a finding reflected in the non-significance of individual cultural variables in logistic regression models, even as descriptive statistics and qualitative evidence confirm their real and powerful influence.

Objective 3 Health System-Related Barriers Affecting Access to Maternal Healthcare

In addition to socioeconomic and cultural barriers, health system-related issues were also a significant hindrance to accessing quality maternal healthcare services. Some key findings included:

Inadequate Health Infrastructure: 85% of participants mentioned that local healthcare facilities lacked the necessary equipment to provide adequate maternal care. One participant shared: *“When I went to the clinic for my checkup, they didn’t have the right equipment to*

check my blood pressure. I had to go to a private clinic in town to get a proper check-up.

“This reflects the challenge posed by under-resourced health facilities.

Shortage of Skilled Healthcare Workers: 40% of women reported that there were not enough trained personnel, such as midwives and doctors, at local health facilities. One participant commented:

“The nurses are few, and sometimes you wait for hours before they see you. It’s frustrating because I don’t have time to wait.” “The shortage of skilled workers leads to delayed and subpar care.

Table 4.17: Descriptive Summary Health System Variables. (n=40)

Variable	Obs.	Mean	Std. Dev.	Min	Max
Facility perceived as adequate	40	0.147	0.355	0	1
Emergency transport available	40	0.241	0.429	0	1
Consistent supply availability	40	0.312	0.465	0	1
Long waiting times experienced	40	0.653	0.477	0	1
Service availability perception (1–4 scale)	40	3.05	0.827	1	4

The figures presented in Table 4.17 shows a clear picture of health system performance at Kaphiri. Only 14.7% of respondents perceived their local facility as adequately resourced meaning over 85% regarded their facility as inadequate, 24.1% had access to emergency transport when needed and 1.2% reported consistent availability of essential maternal health supplies. By contrast, 65.3% experienced long waiting times. The mean service availability perception score of 3.05 on a 1–4 scale, where 3 = "limited availability" and 4 = "not available," confirms that the average woman at Kaphiri perceives maternal services as hovering between limited and unavailable.

Research Findings

Objective 1: Socio-Economic Factors

Socio-economic factors emerged as the primary and most statistically documentable category of barriers. Fifty-seven percent of respondents experienced cost-induced delays (mean = 0.571) and found ANC unaffordable (mean = 0.571). Only 40.6% had transport access when needed. Cross-tabulation confirmed a statistically significant association between income level and ANC unaffordability (Pearson χ^2 (2) = 6.252, p = 0.044, Cramer's V = 0.192). OLS regression confirmed that income poverty at Kaphiri is structurally determined and not explained by individual educational attainment or marital status (F (2, 37) = 0.44, p = 0.646, R^2 = 0.005), necessitating structural rather than individual-level interventions. Box plot

analysis demonstrated that agricultural workers face the highest cost-induced delay burden, reflecting the unique vulnerability of seasonal, informal agricultural livelihoods.

Objective 2: Cultural Beliefs and Practices

Cultural barriers operated through complex, overlapping, and contextual pathways. The results show respondents (48.8%) preferred TBAs over formal facility-based care striking finding that reflects the deep cultural embeddedness of traditional birth practices at Kaphiri. The community view score mean of 3.22 on a 1–4 scale (where 4 = unsupportive) indicates that the average community stance is closely aligned with the "unsupportive" end, confirming widespread social resistance to formal maternal healthcare.

Objective 3: Health System-Related Barriers

The results indicated that 14.7% of respondents perceived their facility as adequate, 24.1% had emergency transport access, 31.2% reported consistent supply availability; and 65.3% experienced long waiting times. The mean service availability perception of 3.05 on a 1–4 scale confirms that women perceive maternal services as ranging from limited to unavailable. Multinomial logistic regression confirmed that staff inadequacy significantly predicts "not available" service perception (coefficient = 1.481, $p = 0.005$), and that reduced waiting times significantly increase "very available" perception (coefficient = -2.380, $p = 0.004$), with overall model significance ($\chi^2(6) = 18.71$, $p = 0.005$, Pseudo $R^2 = 0.050$).

CONCLUSIONS FROM THE STUDY

The study confirms that barriers to maternal healthcare access at Kaphiri are multifaceted, mutually reinforcing, and deeply embedded across three intersecting domains. Critically, all three categories of barriers map onto the Three Delays Model. The first delay in deciding to seek care is driven by cost barriers, cultural stigma against facility-based delivery, and patriarchal decision-making constraints. The second delay in reaching a healthcare facility is driven by transport absence and geographic distance. The third delay in receiving adequate care upon arrival is driven by staff shortages, equipment deficits, supply stock-outs, and long waiting times.

The health system findings are particularly urgent. With only 14.7% of respondents rating facilities as adequate, 24.1% having emergency transport access, and the findings document a health system failing its most vulnerable users at a systemic level. The finding also indicates that income poverty is structurally determined and unresponsive to individual educational advancement confirms that reducing maternal health barriers at Kaphiri demands macro-level structural intervention addressing agricultural livelihoods, rural economic infrastructure, and

health system investment simultaneously.

RECOMMENDATIONS

Addressing Socio-Economic Barriers

Given the statistically confirmed association between low income and ANC unaffordability and the structural determination of income poverty (OLS $R^2 = 0.005$), the Government of Malawi, through the Ministries of Health and Finance, should introduce a targeted conditional cash transfer programme for pregnant women earning below MWK 150,000 per month. Transfers should cover transport costs, food allowances during facility stays, and other indirect healthcare costs. The Ministry of Health, in partnership with district councils and NGOs, should deploy biweekly mobile maternal health outreach clinics at Kaphiri, reducing the geographic access barrier cited by 45% of respondents while addressing the transport constraint (only 40.6% had transport access).

Addressing Cultural Barriers

The Ministry of Health and community-based organizations should implement structured community dialogue programmers targeting husbands, TBAs, community elders, and traditional leaders. Given that 37.6% of women require spousal permission to seek healthcare, male engagement programmes promoting shared reproductive health decision-making should be a centerpiece of cultural change strategies (Bohren et al., 2015). TBAs should be formally integrated into the community health referral pathway as trained community health agents rather than competitors to formal care.

Addressing Health System Barriers

An emergency obstetric transport system for Kaphiri should be established as a matter of priority, supported by WHO, UNFPA, and international development partners, given that only 24.1% of respondents had emergency transport access. Community-based emergency transport committees with designated vehicles and mobile phone dispatch systems represent scalable and cost-effective models for the Malawian rural context. Facility infrastructure investments should priorities essential diagnostic equipment, reliable electricity and clean water, postnatal care wards, and expanded consultation spaces to reduce congestion and waiting times.

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