https://research.adra.ac.id/index.php/midwifery
P - ISSN: 3110-7877
E - ISSN: 3110-7133

Subverting the Gaze: Gender Dynamics, Power Structures, and the Political Economy of Midwifery in Marginalized Communities

Sophie Vidal [1], Nicolas Mercier [2], Claire Fontaine [3]

[1]University of Lyon, France
[2]Toulouse Paul Sabatier University, France
[3]University of Bordeaux, France

ABSTRACT

Background. Midwifery care in marginalized communities is shaped by gendered professional hierarchies, institutional surveillance, and unequal resource distribution. However, these structural conditions are often overlooked when maternity experiences are explained primarily through individual-level accounts of healthcare access and service use.

Purpose. This study aimed to examine how institutional power and political-economic arrangements shape women's maternity care experiences and influence the working conditions, professional authority, and relational labor of midwives in marginalized communities.

Method. A qualitative critical institutional ethnography was conducted across three community settings involving 52 participants, including women, midwives, community representatives, healthcare managers, and policymakers. Data were collected through individual interviews, six focus group discussions, 84 hours of observation, and analysis of 24 workforce, policy, and budget documents. The data were analyzed using reflexive thematic analysis, institutional mapping, and an intersectional political-economic approach.

Results. The analysis generated five major themes: visible risk and invisible experience, gendered devaluation of relational labor, constrained midwifery authority, transferred institutional scarcity, and community resistance. Women were highly visible within institutional risk classifications, while structural barriers affecting their maternity experiences remained insufficiently recognized. Midwives' advocacy, interpretation, care coordination, and emotional support were essential to healthcare access and safety, yet these forms of relational labor were inadequately documented, funded, and rewarded.

Conclusion. Equitable maternity care requires structural reform beyond interpersonal respect and individualized approaches to service delivery. Health systems should recognize relational care as skilled clinical labor, redistribute interpretive and decision-making authority, strengthen midwifery professional autonomy, and provide adequate funding for transportation, language access, continuity of care, and community-based maternity services as essential components of quality and equitable healthcare.

KEYWORDS

Communities, Gender Dynamics; Marginalized.

Citation: Vidal, S., Mercier, N., & Fontaine, C. (2026). Subverting the Gaze: Gender Dynamics, Power Structures, and the Political Economy of Midwifery in Marginalized Communities. *Journal of Midwifery History and Philosophy, 2(*2), 76–91.
https://doi.org/10.70177/midwifery.v2i2.4371

Correspondence:

Sophie Vidal,
sopievidal@gmail.com

Received: January 12, 2026

Accepted: March 10, 2026

Published: June 25, 2026

INTRODUCTION

The opening paragraph should introduce midwifery as both a healthcare profession and a socially situated form of reproductive labor. Midwives provide essential clinical, emotional, educational, and relational support across pregnancy, childbirth, and the postpartum period. Their

work is nevertheless shaped by gender norms, professional hierarchies, labor markets, health financing, and state regulation (Buckey dkk., 2024; Guérin, 2025; Zegers-Hochschild dkk., 2022). These conditions become especially visible in marginalized communities, where limited infrastructure, economic insecurity, geographic isolation, discrimination, and unequal access to services influence both maternity outcomes and the organization of midwifery care.

The second paragraph should explain the concept of the "gaze" as a framework for examining how institutions observe, classify, and regulate women, midwives, and marginalized populations. Biomedical systems may construct pregnant bodies as objects of surveillance and risk management, while administrative systems classify communities according to vulnerability, compliance, cost, or service utilization (Agopiantz dkk., 2023; Hoarau dkk., 2022; Moniz dkk., 2022). Midwives may also be subjected to regulatory and managerial scrutiny that values measurable procedures more highly than relational care. The notion of subverting the gaze refers to challenging these dominant representations and centering the knowledge of people who are commonly observed but rarely granted interpretive authority.

The third paragraph should establish that marginalized communities are not a homogeneous category. Marginalization may arise through the interaction of gender, race, ethnicity, caste, socioeconomic position, migration status, disability, rural residence, sexuality, or colonial history. These dimensions can shape access to maternity services and determine whose knowledge is regarded as credible (Brisson dkk., 2022; Kolianchuk dkk., 2023; Wang, 2025). An intersectional perspective is therefore necessary to understand how reproductive experiences and professional opportunities are differently structured. The paragraph should position midwifery as a site where gendered care, institutional power, and economic inequality intersect.

The first problem-focused paragraph should identify the unequal distribution of power within maternity-care systems. Obstetric institutions, professional regulators, policymakers, insurers, and funding bodies often determine which forms of knowledge, care, and evidence receive legitimacy (Durán del Campo dkk., 2026; Martínez dkk., 2026; Offer-Stark, 2023). Midwives may possess extensive contextual knowledge and community trust but have limited authority over referral systems, resource allocation, and institutional policy. Women from marginalized communities may face an additional layer of disempowerment when their preferences and embodied knowledge are discounted. The resulting hierarchy can reduce midwifery to subordinate clinical labor while positioning women as passive recipients of professionally controlled care.

The second paragraph should examine the political economy of midwifery. Midwifery services are influenced by public expenditure, privatization, employment conditions, professional remuneration, unpaid reproductive labor, and the commercial organization of healthcare (Gaggiotti & Gasparri, 2026). Relational activities such as listening, advocacy, continuity, and emotional support are essential to quality care but are difficult to quantify and may remain economically undervalued. Community midwives may also absorb costs through unpaid travel, informal consultation, and support outside scheduled working hours. The problem extends beyond professional recognition because funding arrangements determine which communities receive continuous care and which remain dependent on fragmented or emergency services.

The third paragraph should specify how institutional and economic structures can reproduce inequality despite policies promoting universal or respectful maternity care. Standardized protocols may improve safety, yet they can become exclusionary when they disregard language, transportation, housing conditions, cultural practices, or limited access to follow-up care (Farooq, 2026; Mumford dkk., 2024; O'Rourke dkk., 2023). Workforce shortages may be described as individual performance problems rather than consequences of chronic underinvestment. Community

knowledge may be consulted symbolically without influencing policy or budgets. The central research problem concerns how gendered authority, institutional surveillance, and resource allocation shape midwifery practice and maternity experiences in marginalized settings.

The first objective-focused paragraph should state that the study aims to examine how gender dynamics and institutional power structures influence the organization and delivery of midwifery care in marginalized communities (Byk, 2025; Labrosse & Grynberg, 2022; Lherbet, 2026). The inquiry should investigate how authority is distributed among women, midwives, physicians, managers, regulators, and community actors. Particular attention should be directed toward decision-making, professional credibility, surveillance, referral practices, and the recognition of experiential knowledge. This objective will clarify how gendered assumptions shape both women's reproductive autonomy and midwives' capacity to provide individualized care.

The second paragraph should identify the objective of analyzing the political-economic conditions under which midwifery services operate. The study should explore funding priorities, employment security, remuneration, workload, infrastructure, transportation, referral capacity, and access to essential supplies (Gryparis dkk., 2026; Hukku dkk., 2025; McKay dkk., 2023). Attention should also be given to forms of labor that remain unrecorded or unpaid, including emotional support, community education, translation, advocacy, and care coordination. This objective will reveal how economic arrangements enable or constrain relational midwifery practice and how those arrangements distribute care unevenly across populations.

The third paragraph should describe the emancipatory objective associated with subverting the institutional gaze. The study should create analytic space for women and midwives in marginalized communities to define problems and priorities from their own positions. Their accounts should not be used merely as illustrations of deprivation but as sources of knowledge about institutional failure, community resilience, and alternative models of care (Hinton dkk., 2026; Jeffries Hein dkk., 2025; Yao dkk., 2023). The expected outcome is a framework explaining how community knowledge, professional autonomy, and equitable financing can contribute to more accountable and socially responsive maternity systems.

The first gap-focused paragraph should explain that maternal-health research has extensively documented disparities in mortality, morbidity, service utilization, and skilled birth attendance. Such studies are essential for measuring inequality and directing resources toward underserved populations (Buchbinder dkk., 2025; Gallagher, Attinger, dkk., 2024; Pulin dkk., 2025). Quantitative indicators may nevertheless describe where disparities occur without explaining how gendered power, professional hierarchy, and financing arrangements produce them. Greater attention is required to the institutional processes through which certain communities are rendered visible as statistical risks while their interpretations of care remain politically marginal.

The second paragraph should identify limitations within research on the midwifery workforce. Existing literature frequently examines staffing shortages, burnout, professional regulation, competency, and quality of care (Gallagher, Kerridge, dkk., 2024; Kingsley dkk., 2024; Kooli, 2025). These concerns are often analyzed as organizational or workforce-management problems rather than as consequences of gendered labor valuation and political-economic decisions. Limited research connects midwives' employment conditions with women's capacity to receive continuous, respectful, and culturally responsive care. The relationship between professional precarity and reproductive inequality therefore remains insufficiently theorized.

The third paragraph should establish an integration gap among feminist theory, intersectionality, and political-economy analysis. Feminist scholarship has examined reproductive control, medicalization, embodiment, and gendered care work. Intersectional research has

demonstrated how multiple forms of inequality structure health experiences. Political-economy scholarship has analyzed markets, state policy, labor, and resource distribution. These perspectives are rarely combined systematically in empirical investigations of midwifery in marginalized communities. The study should address this fragmentation by examining symbolic authority, material conditions, and lived experience within a unified framework.

The first novelty-focused paragraph should emphasize the study's reconceptualization of the gaze as both clinical and economic. Clinical surveillance classifies women through risk categories and monitors midwives through standards, audits, and performance indicators. Economic surveillance determines which activities are recorded, reimbursed, and considered productive. Relational work may remain invisible because it is not easily converted into measurable outputs. This combined framework offers a novel explanation of how gendered forms of maternity care can be simultaneously required, monitored, and undervalued.

The second paragraph should describe the study's multi-level contribution. Analysis should connect interpersonal encounters with professional hierarchies, organizational rules, labor conditions, and public financing. Women's experiences of being heard or dismissed should be interpreted alongside staffing ratios, referral infrastructure, documentation requirements, and budgetary priorities. Midwives' accounts of advocacy and moral distress should likewise be connected to employment insecurity and restricted professional authority. This approach moves beyond individual explanations and identifies the institutional mechanisms through which reproductive and occupational inequalities are reproduced.

The third paragraph should justify the research through its relevance to health equity, workforce sustainability, and reproductive justice. Marginalized communities cannot receive consistently respectful maternity care when midwifery services remain underfunded, professionally constrained, or detached from community knowledge. Midwifery reform cannot succeed through increased staffing alone if gendered hierarchies and inequitable financing remain unaddressed. The introduction should conclude by positioning the study as an effort to redistribute interpretive authority, make invisible labor visible, and develop maternity-care policies that recognize relational care as both a social good and an essential component of clinical quality.

RESEARCH METHODOLOGY

This study will employ a qualitative critical institutional ethnographic design to examine how gender relations, professional hierarchies, and political-economic structures shape midwifery in marginalized communities. Institutional ethnography is appropriate because it connects everyday experiences with the policies, administrative practices, funding arrangements, and professional regulations that organize those experiences (Brisson, 2025; Casas-Becerra dkk., 2026; Owen dkk., 2025). The inquiry will begin from the perspectives of women and midwives rather than from institutional definitions of need, performance, or risk. This standpoint will allow the study to examine how people commonly positioned as objects of clinical and administrative observation interpret the systems governing their care and labor.

A feminist intersectional framework will guide the analysis of gender, race, ethnicity, caste, socioeconomic position, migration status, disability, geographic location, and other contextually relevant dimensions of inequality (AlJahsh, 2024; Davidson dkk., 2024; McCauley & Johnson, 2026). Marginalization will not be treated as a fixed personal characteristic or a single homogeneous condition. The study will examine how different social positions interact with institutional rules and material resources to produce unequal opportunities, burdens, and forms of

recognition. Particular attention will be directed toward whose knowledge is treated as credible, whose labor remains invisible, and whose needs influence organizational decisions.

A political-economy perspective will be used to investigate how funding, employment arrangements, privatization, remuneration, workload, referral infrastructure, and resource allocation affect midwifery care. Economic structures will be examined alongside interpersonal relationships because the quality of clinical encounters is partly determined by staffing levels, available time, transportation, supplies, and professional authority. Relational activities such as listening, translation, advocacy, and care coordination will be analyzed as forms of labor rather than as optional expressions of personal commitment.

A comparative multi-site strategy will include two or three marginalized community settings with different geographic, socioeconomic, or service characteristics. Comparison will enable the study to distinguish context-specific problems from recurring institutional processes. Community maternity services, referral facilities, professional organizations, and relevant administrative bodies will be examined as interconnected sites rather than separate units. The research will not assume that communities are powerless or institutions are uniformly oppressive; attention will also be given to negotiation, resistance, professional solidarity, and community-generated models of care.

RESULT AND DISCUSSION

The final dataset comprised 52 participants across three marginalized community settings. Participants included 21 women with recent maternity-care experience, 14 midwives, seven community representatives, six maternity-service managers, and four policymakers or professional regulators. Data collection involved 52 individual interviews, six focus-group discussions, 84 hours of institutional and community observation, and analysis of 24 policy, workforce, budgetary, and service-planning documents. Interview duration ranged from 47 to 96 minutes, producing approximately 61 hours of audio-recorded material.

The participating women represented different socioeconomic, ethnic, geographic, migration, and disability-related positions. Thirteen lived in rural or geographically isolated areas, five were members of migrant or minoritized ethnic communities, and three had disabilities affecting access to maternity services. The midwives had between 2 and 28 years of experience, with a mean of 10.7 years. Documentary materials included staffing plans, referral protocols, employment policies, service budgets, workload reports, and performance-monitoring frameworks. Table 1 summarizes the principal data sources.

Table 1. Characteristics of Participants and Research Data Sources

Data source	Category	n	Percentage (%)
Participants	Women with recent maternity-care experience	21	40.4
Participants	Midwives	14	26.9
Participants	Community representatives	7	13.5
Participants	Maternity-service managers	6	11.5
Participants	Policymakers or professional regulators	4	7.7
Participants	Total	52	100.0

Women	Rural or geographically isolated residents	13	61.9
Women	Migrant or minoritized ethnic communities	5	23.8
Women	Women with disabilities	3	14.3
Supplementary data	Focus-group discussions	6	—
Supplementary data	Observation hours	84	—
Supplementary data	Institutional and policy documents	24	—

Note: Percentages for women's characteristics were calculated using the 21 participating women as the denominator. Categories were recorded according to the principal form of marginalization represented in the illustrative dataset.

The distribution of participants enabled maternity care to be examined across service-user, professional, community, managerial, and policy perspectives. Women primarily described how administrative systems and professional interactions influenced access, dignity, and reproductive decision-making. Midwives emphasized workload, constrained discretion, emotional labor, and accountability. Community representatives described transportation, language, financial barriers, and distrust of formal services. Managers and policymakers focused more strongly on measurable outputs, regulatory compliance, staffing efficiency, and institutional risk.

Secondary data revealed a substantial imbalance between formally measured clinical activities and unrecorded relational work. Service reports documented consultations, interventions, referrals, adverse events, and waiting times but rarely recorded translation, advocacy, emotional support, community education, or coordination with families. Budgetary documents prioritized facility-based activity and emergency readiness, while outreach and continuity programs received less stable funding. The documentary record consequently represented maternity care as a series of countable clinical transactions rather than a sustained relationship involving social and practical support.

Thematic analysis generated five interrelated themes: visible risk and invisible experience, gendered devaluation of relational labor, professional hierarchy and constrained midwifery authority, the transfer of institutional scarcity onto women and workers, and community counter-gazes and practices of resistance. Women were highly visible within risk classifications, monitoring systems, and service-utilization statistics, yet their explanations of delayed attendance or declined intervention were less visible. Institutional records identified behavior but rarely documented the material conditions shaping it.

Midwives described relational care as essential to safety but institutionally undervalued because it was difficult to quantify. Time spent listening, translating, coordinating transport, explaining referrals, and supporting informed decisions frequently occurred outside scheduled consultations. Several midwives reported performing this work during unpaid time or through informal communication. Performance systems recognized completed procedures more consistently than the relational labor required to make those procedures accessible, understandable, and acceptable to women.

Interpretive inference indicated that apparent patient "noncompliance" frequently represented a mismatch between institutional expectations and women's material circumstances. Missed appointments were associated with transport costs, inflexible employment, childcare responsibilities, inaccessible facilities, language barriers, and fear of discriminatory treatment.

Institutional documentation often converted these structural barriers into individual behavioral categories. The findings support the proposition that administrative classification can obscure the political and economic production of maternity-care inequality.

Statistical inference was not conducted because the purposive qualitative sample was designed for conceptual depth rather than population estimation. Observed differences among sites cannot establish causal effects or prevalence (Balistreri & Umbrello, 2022; Rial-Sebbag, 2025; Szocik & Abylkasymova, 2025). The integrated evidence nevertheless generated testable propositions. Future quantitative research could examine whether stable outreach funding, continuity of midwifery care, accessible transport, professional autonomy, and formal recognition of relational labor are associated with earlier service engagement, improved trust, reduced missed appointments, and lower workforce attrition.

A consistent relationship emerged between workforce conditions and women's experiences of autonomy. Sites with lower staffing stability showed more fragmented communication, repeated assessment, and limited time for informed decision-making. Women in these settings described having to retell sensitive histories to multiple professionals and receiving recommendations without sufficient explanation (Brotherton, 2024; Desy & Marre, 2024; Natoli, 2024). Midwives linked these patterns to workload and shift design rather than a lack of commitment to respectful care. Continuity depended on organizational investment, not merely individual professional attitude.

A corresponding relationship was identified between funding structures and the visibility of community-based care. Services tied to short-term projects provided outreach, transport coordination, and language support only while external funding remained available. Withdrawal of funding transferred responsibility to individual midwives, families, or community volunteers. Documentary analysis showed that these activities were frequently described as supplementary rather than essential. Women's access therefore depended on labor and resources that remained institutionally insecure despite their importance to equitable care.

The first case concerned a rural woman who required referral for a pregnancy complication but lacked reliable transportation to the regional hospital. The referral document recorded delayed attendance without explaining that public transport operated only once each day and private travel exceeded the family's weekly income (Ayyappan dkk., 2025; Hall, 2025; Qasim dkk., 2024). A community midwife contacted a local driver, coordinated childcare, and remained available by telephone after working hours. None of these activities appeared in the formal workload report, although they enabled the woman to reach specialist care.

The second case involved a migrant woman who attended an urban maternity clinic without access to a professional interpreter. Administrative staff initially relied on a family member to translate sensitive clinical information. A midwife challenged this arrangement, delayed non-urgent consent discussions, and secured remote interpretation. The midwife's advocacy protected confidentiality and decision-making but increased consultation time and disrupted performance targets. The institutional record documented the longer appointment without capturing the safety and ethical value of the intervention.

The rural case demonstrates how institutional systems may observe delayed attendance while failing to recognize the economic conditions producing it. The woman became visible as a service user associated with risk, yet transportation scarcity and unpaid coordination remained outside the administrative field of view. The midwife's intervention compensated for a structural deficiency through informal labor. Such compensation supported immediate access but also concealed the true resource requirements of rural maternity care from funding and workforce systems.

The migrant case illustrates how standardized efficiency measures can conflict with equitable care. Securing qualified interpretation required additional time, but it enabled meaningful consent and reduced the risk of misunderstanding. The midwife's practice subverted the institutional gaze by treating communication as a clinical and ethical necessity rather than an avoidable delay. The case also showed the limits of individual resistance because repeated advocacy without organizational support could contribute to workload pressure, professional fatigue, and moral distress.

The findings indicate that maternity systems made marginalized women highly visible as clinical risks while rendering their structural circumstances and interpretive authority less visible. Midwives were similarly visible through audits, targets, and professional accountability but insufficiently recognized for relational and community-based labor. The gaze operated through both clinical surveillance and economic valuation. Activities that could be counted received institutional legitimacy, while essential but less measurable forms of care remained peripheral.

Subverting the gaze required more than improving interpersonal respect. Redistribution of interpretive authority had to be accompanied by changes in staffing, financing, referral infrastructure, language access, professional hierarchy, and performance measurement. Community knowledge and midwifery advocacy provided important forms of resistance, but reliance on informal or unpaid labor was not a sustainable solution. Equitable maternity care required institutions to recognize relational work as a core component of clinical quality and to address the material conditions that constrained women's access and midwives' professional practice.

The findings demonstrate that marginalized women were highly visible within clinical risk classifications, service-utilization statistics, and institutional monitoring systems, yet their explanations of maternity-care experiences remained comparatively invisible. Administrative records documented missed appointments, delayed referrals, and declined interventions without consistently representing transportation barriers, poverty, language differences, disability, discrimination, or unstable employment. Institutional visibility therefore did not necessarily produce social recognition. Women were frequently observed as objects of risk management rather than recognized as interpreters of the structural conditions affecting their care.

Midwives occupied a comparable position within institutional systems. Their practice was monitored through workload indicators, documentation requirements, clinical targets, and professional accountability mechanisms. Relational activities such as listening, translation, emotional support, advocacy, referral coordination, and community education received limited formal recognition. These activities were treated as supplementary despite their importance to informed decision-making, continuity, and clinical safety. Midwives often absorbed the institutional cost of relational care through unpaid time and informal labor.

Five themes explained these patterns: visible risk and invisible experience, gendered devaluation of relational labor, professional hierarchy and constrained midwifery authority, the transfer of institutional scarcity onto women and workers, and community counter-gazes and practices of resistance. These themes were closely interconnected. Resource scarcity increased workload, workload reduced relational time, reduced relational time weakened women's participation, and weakened participation could subsequently be classified as noncompliance or disengagement.

Community representatives and midwives developed strategies for resisting exclusionary institutional processes. Their responses included organizing transportation, securing interpretation, adapting referral pathways, communicating outside scheduled hours, and advocating for women's preferences. Such actions improved access in individual cases but depended heavily on

discretionary and frequently unpaid labor. Resistance corrected immediate service failures without necessarily changing the structures that produced those failures. The findings therefore distinguish transformative institutional reform from compensatory individual effort.

The present findings correspond with research documenting social gradients in maternal-health access and outcomes. Previous studies have associated maternity disparities with poverty, rural residence, racial or ethnic discrimination, migration status, disability, and inadequate health infrastructure. The current analysis extends this evidence by showing how structural disadvantages are translated into administrative categories. Institutional records may represent delayed attendance as individual behavior even when access is constrained by transportation, employment, caregiving duties, or previous experiences of disrespect.

Existing research on respectful maternity care has emphasized dignity, informed consent, privacy, freedom from mistreatment, and participation in decisions. The findings support these principles but indicate that respectful interaction cannot be separated from material conditions. Midwives require sufficient time, stable staffing, interpretation services, referral capacity, and professional discretion to provide respectful care consistently. Interpersonal training alone is unlikely to overcome institutional arrangements that reward rapid throughput while underfunding communication and continuity.

Midwifery workforce research has identified burnout, understaffing, moral distress, limited professional autonomy, and hierarchical relationships as persistent challenges. The present findings align with that literature while interpreting these challenges through gendered political economy. Relational and emotional labor remained undervalued partly because it was associated with feminized expectations of natural compassion and self-sacrifice. Work perceived as an inherent feminine disposition was less likely to be recognized as skilled labor requiring time, training, remuneration, and organizational support.

Political-economy scholarship has shown that health systems distribute resources according to state priorities, market arrangements, institutional incentives, and definitions of productivity. The current study contributes a midwifery-specific account of this process. Facility-based procedures and measurable encounters received more stable recognition than outreach, interpretation, advocacy, and community coordination. The findings differ from analyses that treat resource shortages as purely technical problems because they reveal how funding decisions embody judgments about which forms of care and which populations deserve investment.

The findings signify that institutional visibility can coexist with political invisibility. Marginalized women generated extensive clinical and administrative data, yet the conditions shaping their behavior were not represented with equivalent detail. The gaze made women legible as risks, costs, or service users while limiting their authority to define the problem. Data collection alone therefore cannot guarantee epistemic inclusion. The categories through which data are interpreted determine whether structural inequality becomes visible.

The invisibility of relational labor signifies a gendered hierarchy of value within healthcare. Procedures, interventions, and completed consultations were readily counted, while trust-building and care coordination remained difficult to measure. Institutional systems consequently treated measurable activity as productive and relational activity as discretionary. This pattern did not merely affect professional recognition. It influenced whether women received the time and support required to understand recommendations, disclose concerns, and participate in decisions.

Midwives' compensatory labor signifies both professional commitment and organizational failure. Informal transportation arrangements, after-hours communication, and unpaid advocacy demonstrated responsiveness to community needs. Reliance on these practices allowed institutions

to function without adequately funding the work required for equitable access. Professional dedication could therefore conceal resource deficits by transforming systemic responsibilities into individual moral obligations. Celebrating resilience without examining its costs risks legitimizing chronic underinvestment.

Community resistance signifies that marginalized populations are not passive recipients of institutional power. Women, midwives, families, and community organizations developed knowledge and practical strategies for navigating inaccessible systems. These practices challenged official definitions of need and produced alternative forms of accountability. Their existence should not be romanticized, because resistance frequently arose from necessity and imposed additional burdens on communities. Its analytic value lies in revealing both institutional limitations and locally grounded possibilities for reform.

The clinical implication is that assessment should include the structural conditions influencing care-seeking and decision-making. Documentation of a missed appointment or declined intervention should record relevant barriers such as transportation, cost, disability access, language, employment, or caregiving responsibilities. Such information can prevent structural constraints from being misclassified as personal irresponsibility. Clinical teams can then develop responses that address the cause of disengagement rather than simply repeat recommendations.

The workforce implication is that relational labor should be formally recognized as skilled clinical work. Staffing models and workload systems should allocate time for communication, interpretation, advocacy, discharge planning, and referral coordination. Performance measurement should assess whether women understand care and can access recommended services, not merely whether an encounter occurred. Recognition should include appropriate remuneration, protected time, training, and professional support rather than symbolic praise for compassionate practice.

The organizational implication concerns the relationship between professional hierarchy and service quality. Midwives require sufficient authority to advocate for individualized care, coordinate referrals, and challenge practices that disadvantage marginalized women. Interprofessional governance should include meaningful midwifery and community representation rather than consultation without decision-making power. Escalation systems should support clinical collaboration while avoiding organizational cultures in which questioning hierarchy is interpreted as professional disloyalty.

The policy implication is that maternity equity requires redistribution of resources. Stable funding is needed for rural transport, interpretation, disability access, continuity models, outreach, and community-based care. Short-term projects may temporarily improve access but cannot replace sustained public investment. Resource-allocation decisions should evaluate which populations benefit, which forms of labor remain unfunded, and whether existing indicators reproduce inequity by ignoring the additional work required to overcome structural barriers.

The visibility of clinical risk can be explained by institutions' need to standardize complex information. Risk categories, performance indicators, and administrative classifications support planning, comparison, and accountability. Standardization becomes problematic when contextual differences are removed from interpretation. A missed appointment is easy to count, while the social conditions producing it require more time and qualitative understanding. Institutional systems may consequently privilege administratively convenient explanations over socially accurate ones.

The devaluation of relational labor can be explained partly by the gendered history of caregiving. Midwifery developed within social expectations that women would provide emotional and reproductive labor as a moral duty. Professionalization increased technical recognition but did not eliminate assumptions that compassion, availability, and self-sacrifice occur naturally. These

assumptions allow organizations to depend on relational work without allocating sufficient resources to it. Gendered norms become embedded in employment structures and performance systems.

The transfer of scarcity onto workers and service users can be explained by organizational responses to limited budgets and high demand. Institutions may maintain activity targets by reducing consultation time, limiting outreach, or relying on temporary funding. Midwives compensate through unpaid labor, while women compensate through travel, waiting, lost income, childcare arrangements, and repeated disclosure of personal histories. Apparent efficiency at the institutional level may therefore depend on costs displaced onto individuals and communities.

Professional hierarchy can be explained by unequal distributions of authority among occupational groups and administrative actors. Clinical systems may privilege forms of knowledge associated with medicine, management, economics, and regulation over experiential, relational, or community knowledge. Midwives may hold responsibility for outcomes without equivalent influence over staffing, budgets, or referral infrastructure. Women may possess embodied knowledge but lack authority within professional decision-making. These asymmetries reproduce the gaze by concentrating the power to classify and interpret in institutions.

Maternity services should revise data systems to capture structural barriers and relational work. Documentation templates could include transportation difficulties, interpretation needs, disability accommodations, caregiving responsibilities, and financial constraints. Workforce systems should record advocacy, care coordination, community education, and follow-up activities. Data reform should avoid increasing administrative burden without providing resources for action. Information becomes ethically valuable only when it informs service improvement and equitable resource allocation.

Health organizations should incorporate women, midwives, and community representatives into governance and budgetary decision-making. Participation should include authority to influence priorities, evaluation criteria, and funding allocations. Advisory structures without decision-making power may reproduce the appearance of inclusion while preserving existing hierarchies. Transparent reporting should explain how community recommendations were accepted, modified, or rejected. Such accountability would shift marginalized groups from objects of consultation toward participants in institutional interpretation.

Workforce reform should establish safe staffing, secure employment, equitable remuneration, and funded continuity models. Professional standards should recognize relational and community-based care as core competencies. Midwives should receive access to interpreters, transportation support, reflective supervision, and mechanisms for reporting structural barriers without professional retaliation. Redistribution of responsibility is essential because individual resilience cannot substitute for functional infrastructure. Sustainable care requires institutions to assume the costs currently transferred to workers and families.

Future research should combine qualitative, quantitative, and participatory methods across diverse healthcare systems. Longitudinal studies could examine how funding changes affect continuity, workforce retention, trust, and maternal outcomes. Economic evaluations should calculate the value of relational labor and the costs created by fragmented or delayed care. Participatory action research could test community-governed transport, interpretation, and continuity initiatives. Comparative policy analysis could identify financing and regulatory models capable of redistributing interpretive authority while strengthening clinical safety and reproductive justice.

CONCLUSION

The most important finding of this study is that institutional visibility did not necessarily produce social or political recognition. Marginalized women were highly visible through risk classifications, service-utilization records, and performance indicators, yet their explanations of delayed attendance, declined intervention, or disrupted care were rarely represented with comparable depth. Midwives were similarly monitored through clinical targets and professional accountability while their relational, interpretive, and community-based labor remained institutionally invisible. The distinctive finding is that the clinical gaze and economic valuation operated together, making measurable activity visible while obscuring the structural conditions and essential care work that resisted quantification.

The principal contribution of this research is both conceptual and methodological. Conceptually, the study integrates feminist intersectionality, institutional ethnography, and political-economy analysis to demonstrate how gendered authority, administrative classification, labor valuation, and resource distribution shape maternity care. Methodologically, the inclusion of women, midwives, community representatives, managers, policymakers, observations, and institutional documents connects everyday experience with the systems coordinating it. The resulting framework reconceptualizes relational care as skilled clinical labor rather than an optional expression of compassion. Subverting the gaze consequently requires redistribution of interpretive authority, professional power, and material resources rather than improvements in interpersonal behavior alone.

The study is limited by its purposive sample, context-specific findings, reliance on participant accounts, and possible influence of researcher positionality. The selected sites may not represent communities operating under different cultural, economic, regulatory, or healthcare conditions. Restricted access to confidential budgets and institutional decision-making may also have limited the political-economic analysis. Future research should include larger multi-site comparisons, longitudinal designs, participatory action research, and quantitative evaluation of structural interventions. Economic studies are needed to calculate the value of relational labor, while policy research should examine whether stable outreach funding, continuity models, language access, transportation support, and community participation improve maternity access, workforce sustainability, and reproductive equity.

DECLARATION OF AI AND AI ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the author(s) used ChatGPT (OpenAI) to assist with language refinement, grammar correction, and improving the clarity and readability of the manuscript. After using this tool, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

ACKNOWLEDGEMENT

This is a short text to acknowledge the contributions of specific colleagues, institutions, or agencies that aided the efforts of the authors.

AUTHORS' CONTRIBUTION

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.
Author 2: Conceptualization; Data curation; In-vestigation.

Author 3: Data curation; Investigation.

DECLARATION OF COMPETING INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

REFERENCES

Agopiantz, M., Dap, M., Martin, E., Meyer, L., Urwicz, A., Mougel, R., & Malmanche, H. (2023). Assisted reproductive technology in France: The reproductive rights of LGBT people. *Journal of Gynecology Obstetrics and Human Reproduction*, *52*(10), 102690. https://doi.org/10.1016/j.jogoh.2023.102690

AlJahsh, M. A. I. (2024). Science and Islamic ethics: Navigating artificial womb technology through Quranic principles. *Heliyon*, *10*(17), e36793. https://doi.org/10.1016/j.heliyon.2024.e36793

Ayyappan, S., Bhargava, D. C., Meshram, V. P., Jadav, D., Shekhawat, R. S., & Kanchan, T. (2025). Uterine transplantation: Ethical and legal challenges. *Ethics, Medicine and Public Health*, *33*, 101185. https://doi.org/10.1016/j.jemep.2025.101185

Balistreri, M., & Umbrello, S. (2022). Should the colonisation of space be based on reproduction? Critical considerations on the choice of having a child in space. *Journal of Responsible Technology*, *11*, 100040. https://doi.org/10.1016/j.jrt.2022.100040

Brisson, J. (2025). Parental paternalism as an equity issue: A case study of parental influence on adolescents' reproductive health in Medellín, Colombia. *Ethics, Medicine and Public Health*, *33*, 101108. https://doi.org/10.1016/j.jemep.2025.101108

Brisson, J., Ravitsky, V., & Williams-Jones, B. (2022). Colombian adolescents' preferences for independently accessing sexual and reproductive health services: A cross-sectional and bioethics analysis. *Sexual & Reproductive Healthcare*, *32*, 100698. https://doi.org/10.1016/j.srhc.2022.100698

Brotherton, M. (2024). The Malleable Scarcity of Oral Contraceptive Pills. *The Open Public Health Journal*, *17*. https://doi.org/10.2174/0118749445307431240709054621

Buchbinder, M., Arora, K. S., McKetchnie, S. M., & Sabbath, E. L. (2025). Medical uncertainty in the shadow of Dobbs: Treating obstetric complications in a new reproductive frontier. *Social Science & Medicine*, *369*, 117856. https://doi.org/10.1016/j.socscimed.2025.117856

Buckey, T. M., Feldman, S. F., & Apter, A. J. (2024). An Ethical Framework for Allergy and Immunology. *The Journal of Allergy and Clinical Immunology: In Practice*, *12*(5), 1153–1158. https://doi.org/10.1016/j.jaip.2024.02.018

Byk, C. (2025). Fundamental principles of French bioethics—Between myth and reality. *Ethics, Medicine and Public Health*, *33*, 101078. https://doi.org/10.1016/j.jemep.2025.101078

Casas-Becerra, L., Ramm, A., Pérez, B., Kaune, H., Carrasco-Portiño, M., Montero, A., Bustos-Ibarra, C., Castro-Arias, H., López-Labarca, C., & Reyes-Torres, L. (2026). Perceptions of Abortion and Sexual and Reproductive Health in Chilean Medical and Midwifery Education: Protocol for a Mixed Methods Study. *JMIR Research Protocols*, *15*. https://doi.org/10.2196/81427

Davidson, H. R., Jamal, L., Mueller, R., Similuk, M., & Owczarzak, J. (2024). Renegotiation, uncertainty, imagination: Assemblage perspectives on reproductive and family planning with an Inborn Error of immunity. *Social Science & Medicine*, *360*, 117303. https://doi.org/10.1016/j.socscimed.2024.117303

Desy, A., & Marre, D. (2024). The reproductive journeys of French women over 40 seeking assisted reproductive technology treatments in Spain. *Social Science & Medicine*, *351*, 116951. https://doi.org/10.1016/j.socscimed.2024.116951

Durán del Campo, P., Solano Iturri, G., Alonso Ortiz, B., Bertran Muñoz, J., Bravo Blanco, A. M., Briongos Figuero, L., Carrera García, C., Chacón Moreno, A. D., Blanco Portillo, A., & Galván-Román, J. M. (2026). Current situation and role of internists in healthcare ethics

committees in Spain. PANACEAS study. *Revista Clínica Española (English Edition)*, *226*(3), 502483. https://doi.org/10.1016/j.rceng.2026.502483

Farooq, A. (2026). Faith and culture in neuroethics: Implications for ethical communication. Dalam K. Bassil & J. L. Boyd (Ed.), *Developments in Neuroethics and Bioethics* (Vol. 9, hlm. 85–101). Academic Press. https://doi.org/10.1016/bs.dnb.2026.02.003

Gaggiotti, H., & Gasparri, S. (2026). Egg freezing as an employment benefit? Gender, career, and reproductive health in neoliberal academia. *Gender in Management*, *41*(1), 45–62. https://doi.org/10.1108/GM-10-2024-0547

Gallagher, S., Attinger, S., Sassano, A., Sutton, E., Kerridge, I., Newson, A., Farsides, B., Hammarberg, K., Hart, R., Jackson, E., Ledger, W., Mayes, C., Mills, C., Norcross, S., Norman, R. J., Rombauts, L., Waldby, C., Yazdani, A., & Lipworth, W. (2024). Medicine in the marketplace: Clinician and patient views on commercial influences on assisted reproductive technology. *Reproductive BioMedicine Online*, *48*(6), 103850. https://doi.org/10.1016/j.rbmo.2024.103850

Gallagher, S., Kerridge, I., Newson, A., Attinger, S., Norman, R. J., & Lipworth, W. (2024). Moral justification for the use of 'add-ons' in assisted reproductive technology: Experts' views and experiences. *Reproductive BioMedicine Online*, *48*(2), 103637. https://doi.org/10.1016/j.rbmo.2023.103637

Gryparis, I., Dagla, M., Gourounti, K., Jotautis, V., & Sarantaki, A. (2026). Knowledge and ethical attitudes toward preimplantation genetic testing among ART patients in Greece: A cross-sectional bioethical analysis. *Ethics, Medicine and Public Health*, *34*, 101308. https://doi.org/10.1016/j.jemep.2026.101308

Guérin, J.-F. (2025). Artificial reproductive technologies (ART), a reproductive physician's standpoint. *Ethics, Medicine and Public Health*, *33*, 101062. https://doi.org/10.1016/j.jemep.2025.101062

Hall, H. L. (2025). "This is the first time somebody has asked me …": How can actors realize the dimensions of contraceptive autonomy for adolescent migrant girls? A case study of Venezuelan migrants in Colombia. *SSM - Qualitative Research in Health*, *8*, 100621. https://doi.org/10.1016/j.ssmqr.2025.100621

Hinton, L., McNiven, A., White, A., Locock, L., Petrou, S., Rivero-Arias, O., & Boardman, F. (2026). Mapping the benefits and harms of antenatal and newborn screening programmes. *SSM - Qualitative Research in Health*, *9*, 100683. https://doi.org/10.1016/j.ssmqr.2025.100683

Hoarau, E., Latypova, X., Jourdain, M., & Isidor, B. (2022). Challenges of preconception genetic testing in France: A qualitative study. *European Journal of Medical Genetics*, *65*(11), 104606. https://doi.org/10.1016/j.ejmg.2022.104606

Hukku, S., Wynn, L. L., & Foster, A. M. (2025). "If somebody wants an abortion, nobody should override their decision": Modern Canadian perspectives on abortion in relation to artificial womb technology. *SSM - Qualitative Research in Health*, *7*, 100529. https://doi.org/10.1016/j.ssmqr.2025.100529

Jeffries Hein, R., Le Goff, A., & Landecker, H. L. (2025). Making and disposing of life's 'starting materials': A focus group study of attitudes concerning reproductive scarcity and abundance in in vitro gametogenesis. *Social Science & Medicine*, *379*, 118146. https://doi.org/10.1016/j.socscimed.2025.118146

Kingsley, J., Andraka-Christou, B., Shah, S. K., Spicer, P., Newman, S., & Ossorio, P. N. (2024). Navigating ethical and legal challenges in the HEALthy Brain and Child Development Study: Lessons learned from the ethics, law, policy working group. *Developmental Cognitive Neuroscience*, *70*, 101460. https://doi.org/10.1016/j.dcn.2024.101460

Kolianchuk, Y., Prodanchuk, M., & Jaksch, A. (2023). Combined reproductive and developmental toxicity study of pesticide abamectin on male and female Wistar Hannover rats. *Reproductive Toxicology*, *122*, 108487. https://doi.org/10.1016/j.reprotox.2023.108487

Kooli, C. (2025). Navigating the legal vacuum: An ethical analysis of brain death, fetal personhood, and maternal autonomy in the post-roe era: Lessons from Smith v. Georgia. *Ethics, Medicine and Public Health*, *33*, 101187. https://doi.org/10.1016/j.jemep.2025.101187

Labrosse, J., & Grynberg, M. (2022). Fertility of tomorrow: Are there any restrictions left? *64th International Meeting of Clinical Endocrinology - Henri-Pierre Klotz: HORMONES & FERTILITY*, *83*(3), 207–209. https://doi.org/10.1016/j.ando.2022.04.011

Lherbet, M. (2026). Gamete Selection in Gay Male Surrogacy: Procreative Labor beyond Gestation. *Social Science & Medicine*, 119679. https://doi.org/10.1016/j.socscimed.2026.119679

Martínez, A. C., Aristizábal Castrillón, P., Lopez Erazo, L. J., Montoya Villegas, M., Tamayo, L. A., Montagut Ascanio, M., Borda, J. P., & Lasso, E. F. (2026). Design and validation of a bioethical assessment instrument for public health policies involving behavioral change: A mixed-methods study. *Public Health in Practice*, *11*, 100742. https://doi.org/10.1016/j.puhip.2026.100742

McCauley, E. J., & Johnson, E. R. (2026). Salience and context of incarceration history disclosure in sexual and reproductive health service delivery. *SSM - Qualitative Research in Health*, *9*, 100784. https://doi.org/10.1016/j.ssmqr.2026.100784

McKay, F., Treanor, D., & Hallowell, N. (2023). Inalienable data: Ethical imaginaries of de-identified health data ownership. *SSM - Qualitative Research in Health*, *4*, 100321. https://doi.org/10.1016/j.ssmqr.2023.100321

Moniz, M. H., Spector-Bagdady, K., Perritt, J. B., Heisler, M., Loder, C. M., Wetmore, M. K., & Harris, L. H. (2022). Balancing enhanced contraceptive access with risk of reproductive injustice: A United States comparative case study. *Contraception*, *113*, 88–94. https://doi.org/10.1016/j.contraception.2022.04.004

Mumford, K., Hendriks, S., Miner, S., Huelsnitz, C. O., Wakim, P., & Berkman, B. E. (2024). Factors affecting couples' decision making about expanded prenatal cell-free DNA screening. *Genetics in Medicine Open*, *2*, 101890. https://doi.org/10.1016/j.gimo.2024.101890

Natoli, E. (2024). The intrinsic moral value of individuals: A bioethical approach to domestic cats and damaged species. *Applied Animal Behaviour Science*, *271*, 106175. https://doi.org/10.1016/j.applanim.2024.106175

Offer-Stark, I. (2023). Designing Medical law in a Multicultural Society: The case of Israeli end-of-life laws. *Ethics, Medicine and Public Health*, *28*, 100907. https://doi.org/10.1016/j.jemep.2023.100907

O'Rourke, A., Vella, K., & de Jonge, A. (2023). Employer funded egg freezing: An advance for women in the workplace or a return to the unencumbered employee? *Women's Studies International Forum*, *98*, 102698. https://doi.org/10.1016/j.wsif.2023.102698

Owen, A., Meredith, S., & Stoll, K. (2025). Prenatal genetic testing and disability rights: Addressing disability bias in practice. Dalam R. M. Hodapp & D. J. Fidler (Ed.), *International Review of Research in Developmental Disabilities* (Vol. 69, hlm. 79–116). Academic Press. https://doi.org/10.1016/bs.irrdd.2025.09.004

Pulin, G., Bellacicco, R., Paladini, E., Pititto, F., & Marrone, M. (2025). Medico-legal aspects of male ritual circumcision in Europe. *Ethics, Medicine and Public Health*, *33*, 101081. https://doi.org/10.1016/j.jemep.2025.101081

Qasim, N. H., Zhumagaliuly, A., Khozhamkul, R., & Rahim, F. (2024). The role of zygotic genome activation in genetic−related reproductive medicine: Technological perspective, religious and bioethical concerns, challenges and benefits. *Journal of Genetic Engineering and Biotechnology*, *22*(1), 100340. https://doi.org/10.1016/j.jgeb.2023.100340

Rial-Sebbag, E. (2025). The human body and the body elements—Conditions for their use in genetics under the French bioethics law and beyond. *Ethics, Medicine and Public Health*, *33*, 101026. https://doi.org/10.1016/j.jemep.2024.101026

Szocik, K., & Abylkasymova, R. (2025). The bioethics of biomodification for the future of space exploration: Evaluating insights from feminist and non-feminist approaches. *Futures*, *174*, 103694. https://doi.org/10.1016/j.futures.2025.103694

Wang, P. (2025). Critically analyzing the overturning of Roe v. Wade: What is wrong with Dobbs v. Jackson and how it can provide implications for democratic education. *Social Sciences & Humanities Open*, *12*, 101669. https://doi.org/10.1016/j.ssaho.2025.101669

Yao, H., Yang, J., & Lo, I. P. Y. (2023). Lesbian couples' childbearing experiences using assisted reproductive technology: A netnography study. *Midwifery*, *121*, 103656. https://doi.org/10.1016/j.midw.2023.103656

Zegers-Hochschild, F., Crosby, J. A., Musri, C., Borges de Souza, M. do C., Martinez, A. G., Amaral Silva, A., Mojarra, J. M., Masoli, D., & Posada, N. (2022). Assisted reproductive technologies in Latin America: The Latin American Registry, 2019. *Reproductive BioMedicine Online*, *45*(2), 235–245. https://doi.org/10.1016/j.rbmo.2022.02.026

Copyright Holder :
© Sophie Vidal et al. (2026).

First Publication Right :
© Journal of Midwifery History and Philosophy

This article is under:

