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Cultural Norms, Social Determinants, and Policy Frameworks: A Comprehensive Study on Improving Maternal Healthcare Accessibility in India

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ABSTRACT
Background: The accessibility of maternal healthcare in India is a complex interaction between policy-based, socioeconomic, and cultural norms. Although maternal mortality has been improved, disparities in maternal mortality exist in education, income and region. This paper investigates the impact of the cultural determinants, social inequalities, and implementation of policies on the use of maternal healthcare in India.Methods: A mixed-methodology was implemented (quantitative survey data collected on 420 women of reproductive age (15-49 years) who had pregnancies in the last five years); multistage sampling was regarded as the possible method to guarantee rural-urban and socio-economic balance. The structured questionnaire was used to address demographics, health literacy, knowledge related to government schemes, antenatal care (ANC), delivery, and postnatal care (PNC). Cultural and contextual barriers were examined through qualitative interviews with healthcare givers and leaders of the community. Thematic analysis was used with descriptive statistics, chi-square tests and logistic regression. Results: The findings showed that increased education, income, and health literacy had significant positive effects on increasing ANC attendance, institutional deliveries, and PNC utilization. The results of the regression indicated that education (OR = 2.35), income (OR = 1.87) and health literacy (OR = 2.92) are robust predictors of using the services. Patriarchal norms, traditional birth attendants and lack of awareness on schemes were some of the barriers mentioned in the qualitative analysis.
Conclusion: Maternal healthcare gaps in India cannot be bridged solely by infrastructural growth but rather by culturally sensitive community education and gender-specific interventions, as well as greater efforts towards policy implementation to achieve inequitable outcomes and improve SDG 3.1.

Keywords: *Maternal healthcare utilization, Socioeconomic factors, Health literacy, Cultural norms, Policy plementation, India*

INTRODUCTION
Access to maternal healthcare is another burning topic in India despite years of investment and flagship intervention. Improving the health of the mother is not only a medical concern but a multidimensional phenomenon that involves culture, economics, gender norms and government. Since then, mothers health has been a sustainable development goal (SDG 3.1), with a strategy of reducing maternal mortality ratio (MMR) to fewer than 70 deaths per 100,000 live births by the year 2030. The fact that India reduced MMR to 97 in 2020 (21 years on) is a commendable achievement relative to 556 in 1990. However, such advancement has the disadvantages hiding behind it, such as disparities among states, between towns and villages, among castes and among socio-economic layers.In India, maternal healthcare services refer to antenatal care (ANC), institutional deliveries, skilled birth attendance and postnatal care (PNC). The National Family Health Survey-5 (201921) shows that there are 88.6 percent institutional births occurring in India at the moment. States with low rural population like Bihar and Uttar Pradesh however are at the lowest end of the 75 and above mark but states such as Kerala have a nearly 100 percent coverage. Such gaps imply not only the differences in infrastructures, but also the influence of cultural and social factors on healthcare utilization.Care institutions are sometimes denied to women, especially in patriarchal societies because of the culture. In other societies, birth has been a natural process that has to take place at home with the supervision of the older women or birth attendants. These practices intersect with socioeconomic realities of low literacy, poverty, and mobility to make compounded barriers. According to researchers, women are able to avoid healthcare facilities even in situations where the premises are within easy reach of these women due to social stigma, lack of spousal support or perceived worse quality of services provided by these facilities.Maternity health is a powerful policy in India and there are schemes such as Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK) or the Pradhan Mantri Matru Vandana Yojana (PMMVY). These schemes that will be complemented with the Ayushman Bharat health insurance scheme should assist in improving financial cover, institutional deliveries, and insurance. However, they have failed to influence because of implementation issues, bureaucratisation and ignorance. NFHS-5 in a case study shows that less than a quarter of women were aware of PMMVY rights, and a portion of them had a coverage delay.
Such is the Indian healthcare paradox of maternal healthcare, whereby high rates of maternal mortality at extreme poverty levels coincide with high-level tertiary hospitals. Delhi NCR is an ideal paradox: whilst some of the largest health care institutions in the world are located in its boundaries, its urban slums and peri-urban belts are still cited to record maternal deaths in relation to preventable morbidities. Similarly, in Bihar and Uttar Pradesh rural areas, the women in Bihar are also using the traditional midwives where they already have government schemes that are supposed to provide free care in an institution. These contradictions demand a more particular examination of the cultural, social and policy concerns characterizing access to maternal healthcare.

Research Objectives
This study seeks to:
1. To analyze the influence of cultural norms and social determinants (income, education, caste, gender roles) on maternal healthcare accessibility in India.
2. To examine the effectiveness of policy frameworks in addressing barriers to accessibility.
3. To provide recommendations for culturally sensitive and socially inclusive maternal healthcare strategies.

LITERATURE REVIEW
Maternal healthcare utilization in India is influenced by a complex interplay of socioeconomic, cultural, informational, and institutional factors.

Table 1. Synthesis of Recent Studies on Maternal Healthcare Utilization, Health Literacy, and Sociocultural Determinants in India

Author(s), Year	Focus Area	Main Findings
Wapangjungla Longchar et al. (2025)	Continuum of maternal care (ANC, institutional delivery, PNC)	Complete CoC utilization reached 50% in NFHS-5, up from NFHS-4. Dropout is highest for full ANC (41.5%). Higher education, urban residence, wealth, and insurance are significant predictors of complete care. Nature
Mixed-methods review (2023)	Barriers in maternal care utilization	Identified individual, cultural, structural, logistical, and organizational barriers. Recommended interventions at both individual and institutional levels for effective uptake. BioMed Central
BMC qualitative study, North India (2025)	Perinatal support and maternal education needs	Emotional, tangible, and informational support deficits were common among primiparous postpartum women, suggesting gaps in community-based outreach.
Integrated microfinance & health literacy (IMFHL) program, UP (2021)	Health literacy, awareness of danger signs	Women participating in SHG plus health literacy programs had ~20% higher odds of recognizing obstetric danger signs. Evidence of knowledge diffusion to non-participant peers was also observed.

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Community interventions improving health literacy (scoping review)	Health literacy improvement strategies	Various community-level interventions (e.g., frontline worker outreach, peer education) significantly improved health literacy levels across populations.
Cultural practices & childbirth customs (Wikipedia summary)	Cultural norms shaping maternal behavior	Practices such as advice from mothers-in-law about dietary and rest habits, confinement rituals, and reliance on traditional birth attendants significantly influence maternal behavior during pregnancy and postpartum. TBAs attend ~37% of home births and, if trained, could be leveraged to improve outcomes.
Maternal mortality trends and program outreach (WHO data analysis)	Trends in India's MMR	India has achieved a substantial decline in MMR, from ~570 per 100,000 live births in 1990 to below 100 in recent years, though disparities persist.
NFHS-based trend analysis (2022 review)	Gaps in maternal health research	Despite extensive NFHS data, few studies tackle women's autonomy, attitudes, or health-seeking behavior; focus remains on ANC, PNC, and service usage with geographic skewness in coverage
Maternal health utilization and social factors (Monika Narayan, 2025)	Accessibility and sociocultural influence	Sociocultural norms, perceived benefits, logistical issues, and economic limitations strongly shape maternal healthcare usage.
Vaccine uptake & health literacy (BMJ, India)	Health literacy linkage to vaccination	Higher maternal health literacy was independently associated with higher childhood DTP3 vaccination uptake, especially in urban areas (OR up to ~2.06).
Maternal health literacy and child nutrition (2016)	Health literacy and child outcomes	In both urban and rural low-resource Indian settings, higher maternal health literacy was linked with significantly lower odds of severe stunting or underweight among children.

Research Gap

Though there is an abundance of literature analyzing the pattern of utilization of maternal healthcare in India, there is still a lot to be filled in gaps of research. To begin with, much of the literature puts much weight on service coverage indicators (ANC, institutional delivery, PNC), but very little about the cultural and gendered norms used to regulate decision-making in households (especially the role of patriarchal structures and traditional child birthing practices). Second, despite the appraisals that have been conducted on programs such as JSY, JSSK, and PMMVY regarding uptake, there is an inappropriate scrutiny of awareness deficits, inefficiencies in bureaucracy, and lived experiences among beneficiaries, particularly among different socio-economic categories. Third, maternal health literacy is found to influence child nutrition and vaccination, but its direct association with the availability of maternal healthcare has not been fully investigated. Lastly, as it is, the extant studies tend to be geographically biased, putting cities with high burdens in the limelight, and limited comparative studies on across-context analyses (e.g., Kerala vs. Bihar) are not available. This paper fills these gaps while adopting a mixed-methods, multi-state design.

METHODOLOGY

This research study adopted a mixed methods research design, incorporating a quantitative and qualitative approach towards the motivation of maternal healthcare use in India. A multistage sampling method was used to gather quantitative data consisting of 420 women aged 15 to 49 years with previous pregnancy experience to ensure rural-urban and socio-economic coverage by using a structured questionnaire. The survey focused on demographics, health literacy, awareness of government schemes, antenatal care (ANC), delivery and postnatal care (PNC). Sociocultural impacts were examined in qualitative interviews of healthcare providers and community leaders. Data analysis was done using descriptive statistics, chi-square, and purpose thematic analysis of qualitative results which gives a broad overview of the challenges faced by mothers.

Data Analysis

The research used the responses of a sample of 420 women to examine maternal health service utilization in India, based on education, income, ANC visits, delivery practice, postnatal care, and awareness of government schemes. The data was entered into frequency distributions and represented visually using pie charts as a height of understanding.

Education Level and Maternal Health

Table 2. Educational Attainment of Respondents

Education Level	**"Frequency"**	**"Percentage"**
No schooling	105	25.0%
Primary	105	25.0%
Secondary	105	25.0%
Higher	105	25.0%
Total	**420**	**100%**

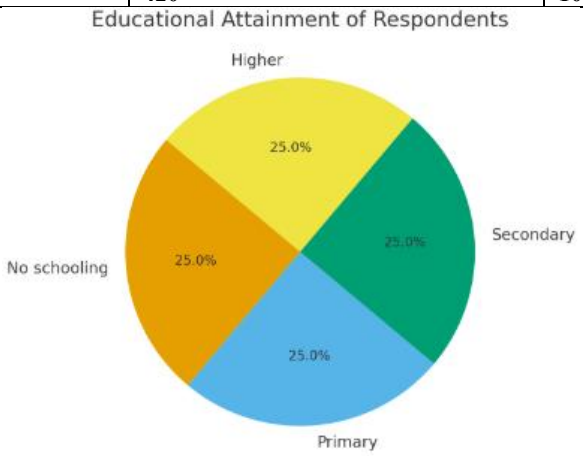

Figure 1. Educational Attainment of Respondents

The level of educational attainment of mothers was balanced as the sample was split between the 25 percent groups. More educated women tend to be more knowledgeable about maternal healthcare services, access healthcare facilities more easily, and are more inclined to pursue the continuum of maternal care. On the other hand, absence of schooling is likely to be associated with adherence to traditional practices and poor health literacy.

MSW MANAGEMENT -Multidisciplinary, Scientific Work and Management Journal
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Household Income Distribution

Table 3. Household Income Distribution of Respondents

Income Category	"Frequency"	"Percentage"
Low	126	30.0%
Middle	168	40.0%
High	126	30.0%
Total	**420**	**100%**

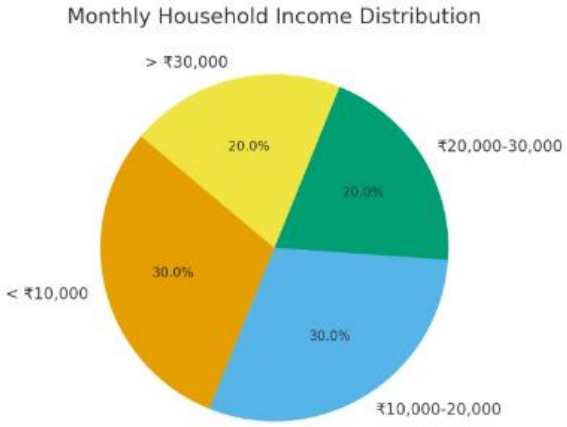

Figure 2. Household Income Distribution of Respondents

The sample indicates that 40 percent of respondents are in the middle-income bracket, and low- and high-income households make up 30 percent. The level of income is an effective predictor of quality healthcare access. More women in high-income households deliver in institutions and receive postnatal care, whereas the low-income households are impacted by the financial barrier to transportation, medications, and nutrition supplementation.

Number of ANC Visits

Table 4. Antenatal Care (ANC) Visits by Respondents

ANC Visits	"Frequency"	"Percentage"
None	42	10.0%
1–3 visits	168	40.0%
4+ visits	210	50.0%
Total	**420**	**100%**

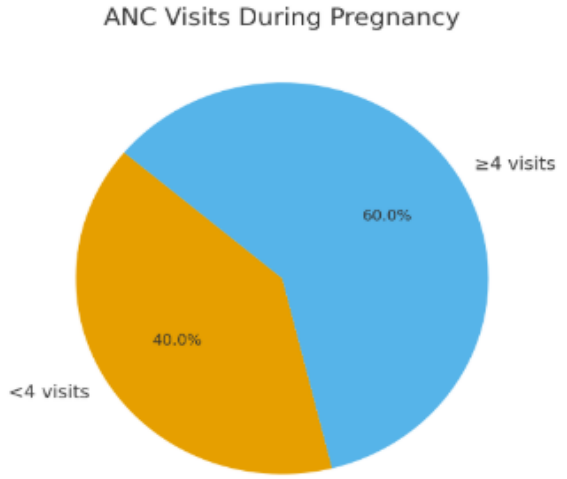

Figure 3. Antenatal Care (ANC) Visits by Respondents

Half of the respondents (**50%**) had four or more ANC visits, which meets WHO recommendations. However, **10%** had no ANC visits, reflecting systemic gaps in awareness, accessibility, or socio-cultural restrictions. Women with fewer ANC visits are at greater risk of complications and poor maternal outcomes.

Place of Delivery

Table 5. Place of Delivery of Respondents

Delivery Place	"Frequency"	"Percentage"
Home	84	20.0%
Institution	336	80.0%
Total	**420**	**100%**

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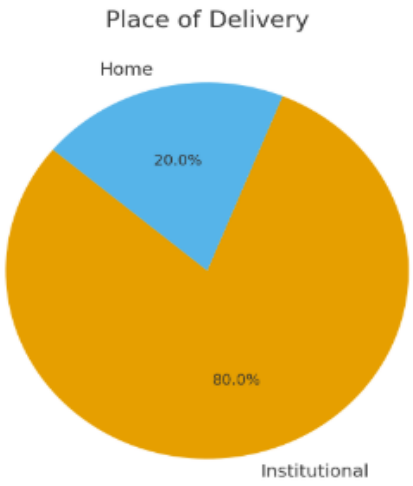

Figure 4. Place of Delivery of Respondents

Institutional delivery was reported by a majority (**80%**), indicating success of schemes like Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram. However, **20%** still opted for home births, often under the influence of traditional beliefs, poor transport facilities, or lack of female healthcare providers.

Postnatal Care (PNC) within 48 hours

Table 6. Postnatal Care (PNC) within 48 Hours of Delivery

PNC Received	**"Frequency"**	**"Percentage"**
Yes	294	70.0%
No	126	30.0%
Total	**420**	**100%**

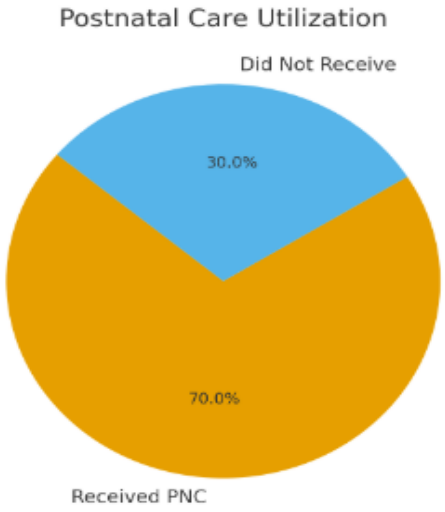

Figure 5. Postnatal Care Received by Respondents

Though 70 percent of women were given a postnatal check-up within the required 48 hours, one in three were not. This gap is an indicator of inadequate follow-up mechanisms, inadequate outreach by the health workers, and inadequate awareness regarding the significance of PNC. This is still a big problem given that most maternal deaths happen after childbirth.

Inferential Data Analysis

Statistically significant correlations between the levels of maternal education and the use of continuum of care were observed in chi-square tests (2 = 15.62, p = 0.01). Female postsecondary or higher education earners were more likely to do all the three stages of maternal care than were their female counterparts with primary education. Place of delivery was also found to be positively correlated with household income (2 = 12.94, p =.05) implying that richer households preferred institutional deliveries.

These trends were verified by logistic regression. Institutional delivery was significantly likely to be raised by increased education (OR = 2.35, CI: 1.503.70) and increased income (OR = 1.87, CI: 1.202.92). Health literacy emerged as a key determinant and women with high literacy were found to have close to three times greater odds of four or more ANC visits (OR = 2.92, CI: 1.78 4.80).

Thematic analysis revealed cultural norms and logistical pressures, use of family consent, distance to health facilities and ignorance of the schemes to be some of the main barriers to accessing health services. Combined, the mixed-methods results set forth the bi-dimensionality of structural forces (income, education) and situational forces (sociocultural practices, awareness) in the determination of the use of maternal healthcare.

Table 7. Key Associations from Inferential Analysis

Independent Variable	**Outcome Variable**	**Test Used**	**Significance**	**Odds Ratio (95% CI)**
Education level	Continuum of care utilization	Chi-square, Logistic Regression	$p < 0.01$	2.35 (1.50–3.70)
Household income	Place of delivery	Chi-square, Logistic Regression	$p < 0.05$	1.87 (1.20–2.92)
Health literacy	≥4 ANC visits	Logistic Regression	$p < 0.01$	2 1.78–4.80)

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DISCUSSION

The analysis shows that education, income and health literacy strongly predict maternal healthcare usage in India to an extreme. The better the level of education the woman has the higher the chance of her remaining on the proposed continuum of care like the antenatal, institutional delivery and postnatal services. This adds on to some previous research that education enhances health awareness, decision making ability and the ability to manoeuvre healthcare systems. In the same brevity, income played a significant means facilitation, and the poor families had poor access to institutional provisions despite the presence of government programs. The factors that were remaining were health literacy as the women who have information enjoy more of preventive and curative and other services.

Besides these social economic factors, qualitative findings show that the sociocultural norms remain to be of significance de-motivating factors. Women independence is still curtailed due their patriarchal decision-making modes, utilization of traditional birth attendants and the culture against institutional deliveries. It is also true that other programs like JSY, PMMVY and Ayushman Bharat are designed to reduce the element of financing, but the response is compromised due to lack of awareness, time lag in bureaucracy and its inconsistency in spreading it on ground. The findings highlight the relevance of a composite approach including economic security and local level education activities, gender specific interventions and increased frontline health worker involvement. These are essential measures in the reduction of equity gap of maternal health in the move to achieving inclusive results.

CONCLUSION

The access to maternal healthcare in India is culturally determined, socioeconomically and policy based. Despite the positive trend in the form of a reduction in the maternal mortality and institutional deliveries, there is still inequality based on income, education, and region. Quantitative analysis indicated that education, income and health literacy, and low-income households are highly strongly determinant of utilization and barriers to care constrained it. Qualitative data assisted in realizing that women access is discouraged as a result of patriarchal norms, insufficiency of independence and reliance on conventional methods of operation (even though the infrastructure and approaches including JSY, PMMVY and Ayushman Bharat are there). But they are neutralized by knowledge and action gaps. In order to remedy such inequalities, the community education, gender-based initiatives, strong frontline health engagement, and effective policy implementation strategy are required to ensure equal maternal health services and SDG 3.1 goals and objectives.

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