



Maternal Mental and Physical Health in Birth Decision-Making: A Systematic Qualitative Review from Tamil Nadu, India Short Running Title: “Maternal Health and Birth Decisions in Tamil Nadu.”

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ARTICLE INFO	ABSTRACT
Published Online: 03 November 2025	Background: This review explores how maternal mental and physical health interact to shape childbirth decision-making in Tamil Nadu, India. Methods: Following PRISMA 2020 guidelines, qualitative studies published from 2015 to 2025 were reviewed using the PEOS framework. Sixteen studies involving approximately 825 participants were synthesised through thematic analysis. Results: Six major themes emerged: perceived medical necessity, fear and trauma, autonomy, recovery concerns, family support, and institutional trust. Findings highlight that women’s psychological safety often outweighs clinical advice in birth decisions. Conclusion: Maternal decision-making reflects an ongoing negotiation between physical health and emotional control. Integrating trauma-informed, person-centered care in Tamil Nadu’s maternal programmes is recommended.
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KEYWORDS: Maternal mental health, psychological safety, birth decision-making, autonomy, Tamil Nadu, qualitative synthesis	

INTRODUCTION

The concept of maternal health is an important aspect of both the sphere of public health and global health care and behavioural science, in general, and the context of India, in particular, where the country is determined to achieve the goals of the Sustainable Development Goals directed at the reduction of maternal mortality (Hamal et al., 2020). India has successfully stimulated a massive increase in institutional delivery rates through large-scale policy efforts, such as the National Health Mission (NHM) (Ghosh and Ghosh, 2020). Tamil Nadu stands apart in this environment, as it has always demonstrated a high level of performance and almost universal coverage of institutional births. This is a necessary augmentation in the number of facilities-based deliveries as it ensures the availability of skilled birth attendants and emergency obstetric care. However, despite the level of facility utilisation statistics being a triumph of human health, it only denotes a first step in the protection of maternal health; thus, a more detailed investigation into the personal and

subjective factors that affect the obstetric choice of a woman is justified.

Growth of the institutional delivery coverage is contrasted by the accounts of the worry, terror, and the loss of control that is felt during the birth process. Qualitative research in and around India (the southern areas are no exception) reveals that women are subjected to mistreatment, verbal insults, and high levels of autonomy loss when procedural interventions are imposed without adequate consent (Dogg et al., 2025; Ferede et al., 2022). These elements of the negative experience, which are synonymous with a lapse in the person-centered maternity care (PCMC), significantly increase the anxiety of a woman about labour and affect the choice of surgical birth to ensure maximum psychological safety, thus concealing the physiological nature of labour. The overlap between clinical necessity and mental health imperatives is a determinant of modern birth decisions that remains unexplored, thus demonstrating a large knowledge void.

Empirical studies concentrate mostly on quantifiable physiological predisposing risk factors, such as constant anemia, low maternal stature (Gummadi et al., 2024), inadequate interbirth intervals (Rana et al., 2019a; Dhingra and Pingali, 2021), and signs of socioeconomic hardship (Mondal et al., 2020; Singh et al., 2021). The combination of these variables provides the perception of vulnerability of the individual towards obstetric complications.

The decisions on mode of delivery are theoretically based on the Health Belief Model (HBM) and construed as a balance between objective physiological risk factors (identified by clinical evaluation) and personal assessment of individual agency and predicted psychological morbidity (i.e., emotional distress and pain that are likely to be experienced during spontaneous birth). Once the perceived risk associated with an unassisted vaginal birth is less than the perceived value, pregnant women establish procedural safety and an

illusion of power, often conducting planned cesarean delivery as a means of protecting psychological health.

The impact of physical risk and structural provisions is widely recorded, but relatively low academic interest has been attracted to the way psychological roles, such as anxiety and previous traumas, guide the decision-making process of women in a high-utilization system like Tamil Nadu.

This gap creates a research gap that is potentially central: policy interventions that only respond to structural impediments often fail to consider the powerful internal psychological motivations upon which women base their demands for non-clinical interventions.

Therefore, the current systematic literature review has attempted to integrate qualitative evidence on the relationship between maternal mental and physical health correlates and the aggregate effects on child birth decisions in women and their partners in Tamil Nadu.

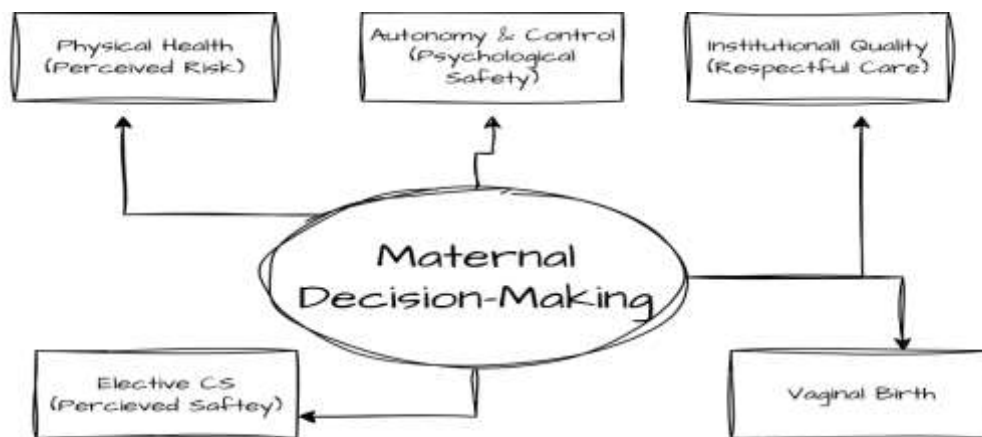


Figure 1 Conceptual Framework of Maternal Decision-Making (interaction between Perceived Risk, Autonomy, and Institutional Quality)

Figure 1: Conceptual Framework of Maternal Decision-Making.

The given framework outlines the relationships between the risks of physical health, autonomy, and the combined notion of psychological safety, and the quality of the institution that determines maternal choice, altogether. The crossover of

these spheres determines the decision made between the elective cesarean section and vaginal birth, therefore, reflecting the balance between the apparent physical need and the psychological health.

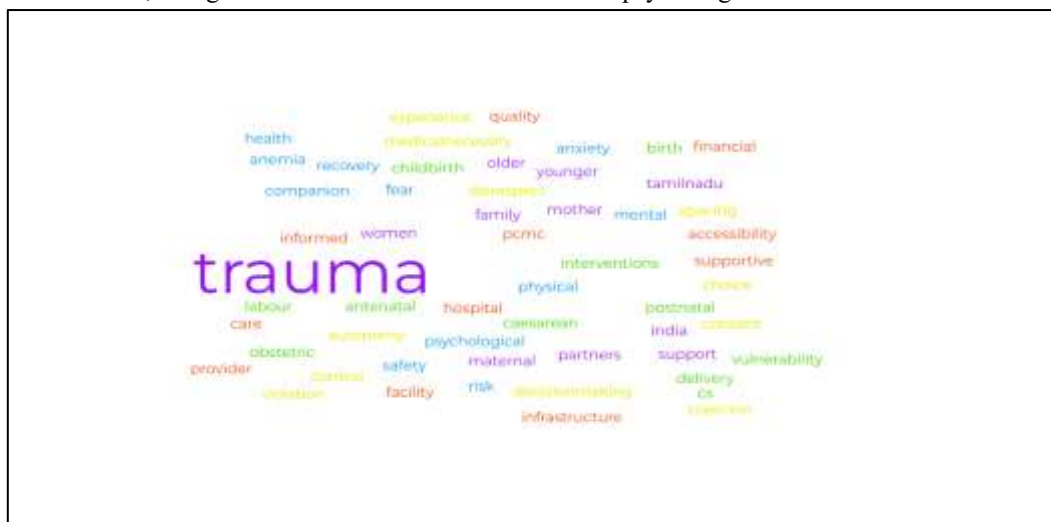


Figure 2: Word Cloud

METHODS

Study Design and Framework

In this study, the researcher uses a qualitative systematic review method that adheres strictly to the guidelines of the Preferred Reporting Items of Systematic Reviews and Meta-analyses (PRISMA2020) in order to ensure comprehensive reporting and reproducibility (Page et al., 2021). The theoretical framework that helped to state the research query and outline the inclusion criteria was the P.E.O.S. (Participants, Exposure, Outcome, Study design) framework. This framework had been carefully, to capture the contextual intricacies of birth decision-making in the sphere of maternal health. The obtained exhaustive parameters of inclusion and exclusion are available in Table 1.

Search Strategy and Screening Process

Two reviewers searched three main electronic databases, including PubMed, CINHB, and Scopus, to perform independent searches with regard to the inclusion of the relevant literature. The search period was very clear (January 2015 to June 2025), thus aiding in narrowing it to the latest evidence in the area. Search queries were limited to Medical Subject Headings (MeSH) and free-text terms in combination and were limited to the geographic area of Tamil Nadu. After searching in the systematic databases, the retrieved titles and abstracts were scrutinized by two reviewers, who went through all the retrieved data and followed the P.E.O.S.

criteria. The inter-rater reliability of the above screenings was measured using Cohen’s Kappa ($k=0.82$), which shows a high degree of concordance. The process of reconciliation of the differences was done in the form of a consensus between the two main reviewers. In Figure 2, the overall flow of identification and selection of the articles is outlined.

Quality Appraisal and Data Synthesis

Quality appraisal articles were then subject to a stringent quality assessment by the use of the Joanna Briggs Institute (JBI) Critical Appraisal Checklist of Qualitative Research. Studies that obtained a score of 7 (and above) of 10 were retained in the final synthesis, hence remaining methodologically sound in qualitative history.

Inductive thematic analysis was the method applied to synthesize the findings.

This process included reading the target articles more than once to help immerse the data in them. Substantive wordings and direct quotes that were related directly to the objectives of the research were picked and coded.

These initial codes were then further grouped into coherent sub-categories, which were then further narrowed and combined into 6 thematic constructs. The inductive approach ensured that the resulting themes were true to the complex, subtle interplay between bodily and psychological determinants inherent in the experiences of women in making birth decisions.

Table 1: Inclusion and exclusion criteria.

Criteria Type	Inclusion Criteria	Exclusion Criteria
Participants (P)	Women who gave birth and men who were partners of women who gave birth in Tamil Nadu, India.	Studies focused on populations outside of Tamil Nadu.
Exposure (E)	Studies that explore influences on maternal mental or physical health that include anxiety, depression, fear of childbirth or the mode of delivery, and birth complications affecting maternal decision-making during the perinatal period.	Studies limited to non-maternal health factors (e.g., purely economic determinants, infrastructure surveys without health linkage).
Outcome (O)	Studies focused on birth decision-making (e.g., choice of delivery location, mode of delivery, refusal of interventions).	Studies whose primary outcome is general health service utilization unrelated to birth choice (e.g., routine vaccination rates).
Study Design (S)	Qualitative research methodology (e.g., interviews, focus groups, narrative analysis). Qualitative data from mixed-methods studies are also included.	Quantitative studies (e.g., cross-sectional surveys, cohort studies, trials, secondary data analysis).
Publication	Original research articles. Published in English. Published within the last decade (i.e., post-October 2015). Ethically approved, peer-reviewed, and full text available.	Review articles (e.g., systematic reviews, meta-analyses, scoping reviews). Theses, dissertations, and conference abstracts. Articles published before October 2015.

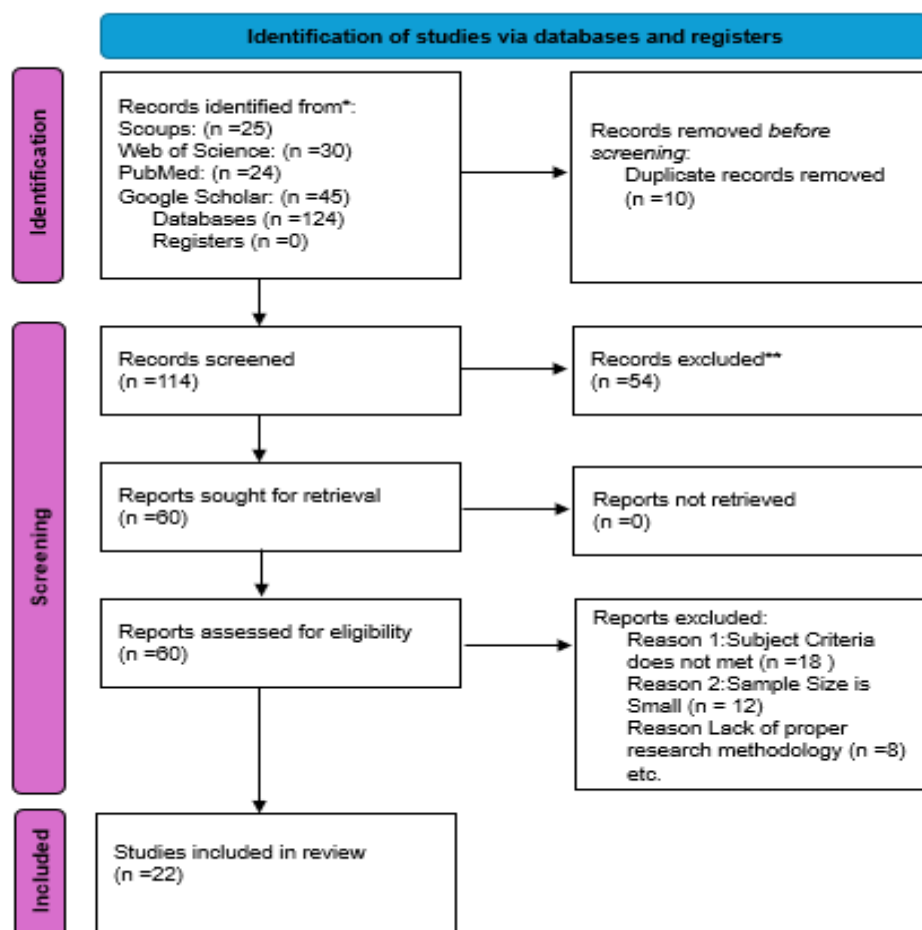


Fig. 2. PRISMA(Page et al., 2021)

The PRISMA flow chart outlines the methodical selection process that has been performed in the review. The preliminary searches in the four databases had 124 records. Having eliminated 10 duplicate articles, 114 articles were screened. This was followed by 54 exclusions and had 60 full-text reports that were eligible to undergo assessment. During

this critical appraisal, 38 reports were excluded due to methodological flaws, small sample size, or not meeting the subject criteria. Following this stringent selection process, a final total of **22 qualitative studies were ultimately included** in the review for data synthesis

Table 2: Characteristics of included articles

Article Type	Title & Author	Objectives	Method and Setting	Result	Gap	Keywords	Journal & DOI Link
Original Research	Planning of births and maternal, child health, and nutritional outcomes: recent evidence from India. (Rana et al., 2019a)	This study comprehensively assesses the effects of birth planning—including timing, spacing, and limiting childbearing—on maternal and child health outcomes. It aims to provide recommendations for maximizing the synergy between maternal, infant, and young children's nutrition and family planning in India.	The study used data from the 2015–2016 National Family Health Survey (NFHS) of India. It applied logistic regression and Cox proportional hazard models to analyze the data. Maternal and child health outcomes were measured by factors like Body Mass Index (BMI), anemia, stunting, underweight, and under-five mortality. The data were collected from a representative sample of 699,686 women using a two-stage systematic random sampling method.	Women with a higher number of births, and those with a first birth less than two years after marriage, had a significantly higher risk of being underweight and anemic. Children born to mothers with a higher number of births and less than three years between births had a higher probability of being underweight and a greater risk of stunting, anemia, and mortality. The findings support the importance of birth planning in improving maternal and child health and nutritional outcomes.	The study addresses a gap in evidence from developing countries regarding the effects of family planning on maternal and child health outcomes. It argues that previous studies often analyzed components of birth planning independently, whereas this study provides a comprehensive framework by examining the combined effects of timing, spacing, and limiting births.	Planning of births, Maternal and child health, Nutrition, Family planning, India.	Public Health, https://doi.org/10.1016/j.puhe.2018.11.019 .

Original Research	Maternal health care in India: A reflection of 10 years of National Health Mission on the Indian maternal health scenario. (Ghosh & Ghosh, 2020)	To examine the National Health Mission's (NHM) impact on India's maternal healthcare by comparing rates of institutional delivery and antenatal care (ANC) services before and after the NHM's launch.	The study used data from India's National Family Health Surveys from 1992–93 to 2015–16. A multivariate logistic regression model was used to analyze factors affecting at least four ANC visits.	The National Rural Health Mission/NHM era saw a 40.2% point increase in institutional deliveries from 2005–06 to 2015–16. However, as of 2015–16, only 51.2% of pregnant women had at least four ANC visits, and wide inequalities persist.	Despite the NHM's success in increasing institutional deliveries, the study reveals a significant gap in the proportion of women receiving at least four ANC visits and highlights persistent interstate and intrastate disparities in maternal healthcare.	Reproductive health Institutional delivery Antenatal care Inequality	Sexual & Reproductive Healthcare https://doi.org/10.1016/j.srhc.2020.100530
Review	Women's experiences of giving birth in healthcare facilities in India -A systematic literature review of qualitative research. (Dögg et al., 2025a)	The study aims to synthesize qualitative research on Indian women's experiences giving birth in healthcare facilities to understand how to improve the quality of care.	A qualitative systematic literature review was conducted in February 2023, using the databases PubMed, CINAHL, and Scopus to identify 16 articles for an inductive content analysis. The studies were set in various urban, rural, and mixed locations across India.	The review found that women's experiences were characterized by a lack of dignity and respect, inadequate supportive care, and limited hospital infrastructure and cleanliness. These factors often deterred them from seeking hospital births in the future.	The review fills a gap in the literature by systematically synthesizing qualitative research on women's experiences in Indian healthcare facilities, moving beyond previous meta-analyses that focused on violence during childbirth.	Childbirth, Experience, Healthcare facilities, South-East Asia.	Sexual & Reproductive Healthcare, https://doi.org/10.1016/j.srhc.2024.101058

Research article	Evidence-based intrapartum care during vaginal births: Direct observations in a tertiary care hospital in Central Sri Lanka.(Weerasingha et al., 2024)	The study aimed to evaluate intrapartum care practices at a tertiary hospital in Central Sri Lanka against WHO recommendations for a positive childbirth experience.	An observational study was conducted at the delivery room of the Teaching Hospital, Peradeniya, Sri Lanka. Data was collected via a non-participant observation checklist from 196 women selected through systematic random sampling.	The study found high use of some WHO-recommended practices like skin-to-skin contact (93.4%) and prophylactic uterotonics (100%). However, labor companionship, upright birth positions, and non-pharmacological pain relief were not observed, and privacy was infrequently provided (33.2%).	This study is the first of its kind in Sri Lanka to assess current childbirth care against WHO recommendations, highlighting a gap in the literature and providing a baseline for future research and policy changes.	Childbirth care, Evidence-based practice, Intrapartum care, Positive childbirth experience, Quality of care.	Heliyon, https://doi.org/10.1016/j.heliyon.2024.e28517
Research article	Understanding the surge in elective cesarean sections: Role of the older Women's childbirth choices among younger women in India.(Dixit et al., 2025)	To investigate the reasons for the rise in elective Cesarean sections (CS) in India, specifically examining how older women's childbirth choices influence younger women within the same household.	The study used cross-sectional data from the National Family Health Survey (NFHS)-5 (2019-2021). It analyzed data from 151,152 institutional births and used multivariable logistic regression and propensity score matching (PSM).	Younger women were more likely to have elective CS if older women in their household had one (29.0% vs. 15.1%). This was especially true in South India, with rates of 40.4%. Other factors included private healthcare, mass media exposure, and higher maternal age.	The study addresses a gap in the literature by focusing on the influence of older women's childbirth experiences on younger women's decisions to have an elective CS, a factor that had been previously underexplored.	Elective cesarean section, Younger women, Older women, India, National family health survey, Propensity score matching.	Global Transitions, https://doi.org/10.1016/j.glt.2025.06.007

Special Contribution(Review)	Infertility services are integrated within The maternal health department of a A public hospital in a low-income country, Rwanda. (Oskowitz et al., 2023)	To describe how to start and integrate reduced-cost infertility services into the maternal health department of a public hospital in a low-income country, Rwanda, and to analyze its costs.	A retrospective review of IVF treatments from 2018–2020 at an academic tertiary referral hospital in Rwanda. The study analyzed clinical and laboratory components and used a government-issued tariff for cost calculations.	Infertility services were successfully integrated and initiated at a public hospital in Rwanda. The projected average cost per IVF cycle was \$1,521 USD. The initiative resulted in five ongoing pregnancies from 207 initiated cycles.	This report addresses the neglected global problem of infertility by demonstrating a successful model for establishing affordable, high-quality infertility services in a public hospital in a low-income country.	Infertility, Rwanda, Africa, low- and middle-income countries, in vitro fertilization (IVF), maternal healthcare services, cost.	Fertil Steril Rep, https://doi.org/10.1016/j.xfre.2023.04.001
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Research article	Temporary childbirth migration and perinatal healthcare in rural Maharashtra, India, (Murro et al., 2025)	To examine the association between temporary childbirth migration (TCM) and the number and timing of perinatal health visits in rural Maharashtra, India.	The study used cross-sectional data from 1288 women who gave birth in 2018-2022 in the Vadu Health and Demographic Surveillance Site (HDSS). Multivariate regression models analyzed the relationship between migration and healthcare visit outcomes.	Migrators and non-migrators had similar outcomes in most areas of care, except for postnatal community health worker visits, which were lower for migrators. Longer natal village stays were linked to fewer prenatal community health worker visits. Women who changed providers had fewer prenatal but more postnatal facility visits.	This study explores the previously unexplored connection between temporary childbirth migration and perinatal care in India. It addresses a gap in understanding how this practice impacts access to different types of maternal and newborn care.	Maternal health, Childbirth, Temporary migration, Internal migration, Care continuum, Antenatal care, Postpartum care.	Journal of Migration and Health, https://doi.org/10.1016/j.jmh.2025.100322
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Original Research	Planning of births and maternal, child health, and nutritional outcomes: recent evidence from India (Rana et al., 2019b)	To assess the effects of birth timing, spacing, and limiting on maternal and child health outcomes, and to provide recommendations for integrating family planning with maternal and child health and nutrition services in India.	Using data from India's National Family Health Survey (NFHS) 2015-16, the study applied logistic regression and Cox proportional hazard models. The study's sample included 437,501 women for BMI, 461,141 for anemia, and 526,868 live births for mortality analysis.	Women with more births, a first birth less than two years after marriage, or less than three years of spacing between births had a higher risk of being underweight and anemic. Their children had higher rates of stunting, underweight, anemia, and mortality.	The study addresses a gap in understanding the combined effects of timing, spacing, and limiting births (a proxy for family planning outcomes) on maternal and child health, rather than analyzing these components individually.	Planning of births, Maternal and child health, Nutrition, Family planning, India.	Public Health, https://doi.org/10.1016/j.puhe.2018.11.019
Original Research	Factors influencing women's and men's place of birth decisions in rural areas Western Highlands Province of Papua New Guinea: A qualitative descriptive study,(Aines et al., 2025a)	To explore the factors influencing women's and men's decisions about place of birth in the rural Western Highlands Province of Papua New Guinea, where many women give birth at home despite seeking skilled care during pregnancy.	A qualitative-descriptive study was conducted in rural villages of the Western Highlands Province, Papua New Guinea. Semi-structured, in-depth interviews were held with 20 participants (16 women and 4 men).	Three key themes were identified: health service accessibility and availability, socio-cultural influences, and previous maternity care experiences. These factors often led participants to reluctantly give birth at home without a skilled provider.	The study addresses a gap in research on maternity care decision-making in the Western Highlands Province of Papua New Guinea, particularly regarding health service accessibility, patriarchal influences, and the impact of previous care experiences.	Birth setting, Decision making, Maternity care, Skilled birth provider, Qualitative, Papua New Guinea.	Women and Birth, https://doi.org/10.1016/j.wombi.2024.101862

Original Research	Person-centered maternity care during childbirth and associated factors among mothers who gave birth at the public health institutions of Debre Markos town, Northwest Ethiopia, 2022: A cross-sectional study,(Alelign et al., 2024)	To assess the magnitude and factors associated with person-centered maternity care (PCMC) during childbirth in public health institutions in Debre Markos, Ethiopia.	An institution-based cross-sectional study was conducted in public health institutions of Debre Markos town, Northwest Ethiopia. The study included 380 women selected via systematic random sampling and used face-to-face exit interviews with a validated PCMC scale.	The mean PCMC score was 56.83 out of 90, which is considered low compared to WHO standards. Women with greater levels of education and those who had more than one partner had high PCMC scores. On the other hand, PCMC scores were linked to poor antenatal care and birth, which was delivered late.	This research fulfills the lack of evidence related to the area of person-centered maternal care (PCMC) in Ethiopia, utilizing a comprehensive and validated tool and considering such variables as the time of antenatal care and the level of education and occupation of the husband.	Childbirth, Debre Markos, Ethiopia, person-centered maternity care.	SAGE Open Medicine, 10.1177/20503121231225352
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Original Research	Maternal Factors Associated with Healthcare Facility Delivery in South Gondar Zone, Amhara Region, Ethiopia,(Biresa w et al., 2025)	To determine the drivers of maternal mortality and health-facility deliveries in the south of the Ethiopian region of Gondar. The key aims of the research were to determine the risk factors, measure prevalence, and reveal the clinical importance of the intervention of the public health to decrease the number of maternal deaths.	A community -based cross-sectional study was carried out in May 2020-May 2021 in the South Gondar area in Ethiopia. The data was collected using an interviewer - administered questionnaire that was given to 434 women between the ages of 15 and 49 years: the sample was selected using a two-stage cluster sampling design.	The researchers found that 76 percent of births were done in hospitals. Other important issues surrounding facility delivery include increased educational levels, availability of road network, which eases admission into the facilities, and exposure to the media. Respondents with primary, secondary, and tertiary education had a statistically significant increase in the probability of delivering in a health care institution.	The study fills a gap in the literature as it provides an in-depth analysis of the factors affecting the use of institutional delivery services in the South Gondar Zone, where the research questions are limited.	Maternal health, South Gondar zone, delivery care, binary logistic regression model.	SAGE Open, 10.1177/21582440251339968
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Original Research	Effects of short birth spacing on birth-order differences in child stunting: Evidence from India,(Dhingra & Pingali, 2021)	In this study, the researcher aims to explain how interpregnancy intervals, as opposed to just ordinal positions of births, are associated with the prevalence of stunting among children under five in India. The research attempts to fill a gap in empirical data with regard to the differentiated impacts of interbirth interval length on the birth-order induced stunting outcomes.	In this study, we analyzed data that relates to 223, 662 children whose ages were below five years of age according to the National Family Health Survey 4, 2007, which was undertaken in India. Linear regression analyses were done, and the Height-for-Age Z-scores (HAZ) of the children were compared with later-born children being stratified on whether the previous birth interval was below three years or above three years.	The height advantage that has been reported previously relative to the birth precedence among the siblings born after the first child is due to the interbirth periods of less than three years. This height difference diminishes with the lapse of time between births that exceed three years. These findings indicate that birth spacing and not birth order is the factor that has a higher impact on the height of children.	The literature gap in this study is reported by proving that fertility decline is not sufficient to handle the negative impact of birth order on children's stunting. As a result, the discussion of the presented findings highlights the importance of the policy interventions that should be focused on increasing interbirth intervals as a means to prevent such harmful outcomes.	Stunting, birth spacing, nutrition, family planning, India.	PNAS, https://doi.org/10.1073/pnas.2017834118
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Original Research	Role of Maternal and Child Health Care Services on Postpartum Contraceptive Adoption in India,(Dixit et al., 2017)	To examine the impact of maternal and child health (MCH) service utilization on the timing and type of postpartum contraceptive use in India.	The study analyzed data from the 2005-2006 National Family Health Survey (NFHS-III), including 36,115 currently married women who had a live birth in the preceding five years.	Women who had more than two antenatal care (ANC) visits were more likely to use modern contraceptive s. Postnatal care was not a significant factor. The study found that all three MCH indicators—ANC visits, institutional delivery, and postnatal care—were significant predictors of early contraceptive adoption.	The study addresses a research gap in India by using calendar data to explore the timing and type of contraceptive adoption after childbirth, a relatively unexplored topic, and by linking MCH service utilization to early adoption of modern contraceptives.	Maternal and child health care, postpartum contraceptive, India, National Family Health Survey-III, ANC visits, institutional delivery, postnatal care utilization, reproductive calendar data.	SAGE Open, 10.1177/2158244017733515
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Original Research Article	Respectful maternity care and associated factors among mothers who gave birth at public health institutions in South Gondar Zone, Northwest Ethiopia 2021,(Ferede et al., 2022)	To assess the prevalence of respectful maternity care (RMC) and associated factors among mothers who gave birth at public health institutions in the South Gondar zone of northwest Ethiopia in 2021.	A systematic random sampling method was used to select 622 participants for face-to-face interviews at public health institutions in the South Gondar zone, northwest Ethiopia, from February 1 to March 30, 2021. A multivariable logistic regression analysis was performed.	Only 39.4% of women received RMC. Factors positively associated with RMC included having completed secondary education, a planned pregnancy, and a daytime delivery. Cesarean section delivery and lack of antenatal care follow-up were negatively associated with RMC.	The study addresses a data gap on RMC in Ethiopia, particularly in rural health facilities, as most previous studies focused on urban areas. It aims to identify contributing factors correlated with disrespectful care in this specific context.	labor and childbirth, public health institutions, respectful maternity care, South Gondar zone.	Women's Health, 10.1177/17455057221116505
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RESEARCH ARTICLE	Women's autonomy and utilization of Maternal Healthcare in India: Evidence from a recent national survey,(Mondal et al., 2020)	To examine the association between women's decision-making autonomy and the utilization of maternal healthcare services in India. The study hypothesizes that women's autonomy increases the likelihood of receiving maternal healthcare services.	The study analyzed data from the National Family Health Survey (NFHS-4) conducted in 2015-2016. The sample included 32,698 currently married women aged 15-49 who had at least one live birth in the past five years and had information available on their autonomy. The study used bivariate and multivariate logistic regression models for the analysis.	Women with a high level of decision-making autonomy were more likely to use maternal healthcare services than women with low autonomy. Specifically, women with high autonomy had a 37% greater likelihood of receiving ANC and a 33% greater likelihood of receiving PNC care compared to women with low autonomy. However, the study found no significant association between women's autonomy and institutional delivery in the adjusted analysis.	Previous studies have mainly focused on socioeconomic and demographic factors, but the autonomy of women in defining maternal healthcare usage in India has not been studied extensively. This paper fills in this gap by using recent nationally representative data to question the relationship between autonomy and use of maternal health services.	Women's autonomy, maternal healthcare, India, national survey.	PLoS ONE, https://doi.org/10.1371/journal.pone.0243553
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Original Article	Association of Maternal Height with Mode of Delivery and Perinatal Outcome,(Gum madi et al., 2024)	The study's primary objective is to determine the relationship between a mother's height and her mode of delivery, as well as the maternal and neonatal outcomes. The goal is to find a simple risk indicator for preventing unnecessary complications, especially in rural areas where antenatal care is often provided by traditional birth attendants.	The study recruited 680 first-time pregnant women at G Kuppuswa my Naidu Memorial Hospital in Coimbatore from December 2019 to August 2020. The women were divided into two groups: those shorter than 150 cm (study group) and those taller than 150 cm (control group).	Short stature (<150 cm) was found to be an independent risk factor for cesarean delivery due to cephalopelvic disproportion (CPD). The incidence of induced labor was higher in the short-stature group (66.35%), as was the rate of emergency LSCS due to CPD (60%). Short-statured mothers also had a significant correlation with babies being born with low birth weight.	The study addresses a need for a simple and reliable risk indicator for obstetric outcomes in countries like India, especially in rural areas where access to advanced antenatal care is limited. It provides data on the relationship between maternal height and delivery outcomes, which has limited information among the South Asian population.	Maternal height, obstetrical delivery, and perinatal outcome.	Apollo Medicine, 10.1177/09760016241245605
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RESEARCH ARTICLE	Determinants of birth registration in India: Evidence from NFHS 2015–16,(Kumar & Saikia, 2021)	To examine the effect of socioeconomic , demographic, and healthcare factors on birth registration in India and analyze the spatial patterns of birth registration completeness at the district level.	The study used data from the National Family Health Survey (NFHS-4) from 2015-16, with a sample of 225,867 children under five from 640 districts and 36 states/UTs of India. Multilevel binary logistic regression was used to identify significant factors at the individual, district, and state levels.	Birth registration was below the national average (80.21%) in 254 districts. Children of mothers with no formal education, no media exposure, or from the poorest wealth quintile and Muslim households had lower odds of birth registration. The study also found that living in a district with a higher proportion of institutional births and vaccinated children significantly increased the odds of birth registration.	The study addresses a lack of systematic research on birth registration predictors in India at the individual, district, and state levels. Previous studies were limited by small sample sizes and often focused on other countries.	Birth registration , India, Determinants, NFHS 2015-16, Spatial pattern, Multilevel analysis	PLOS ONE, https://doi.org/10.1371/journal.pone.0257014
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RESEARCH ARTICLE	Maternal health care service utilization among young married women in India, 1992–2016: trends and determinants,(Singh et al., 2021)	To examine the trends and determinants of full antenatal care (ANC) and skilled birth attendance (SBA) among young married women (aged 15-24 years) in India.	The study analyzed data from four rounds of India's National Family Health Surveys (NFHS-1 to NFHS-4) spanning from 1992-93 to 2015-16. The sample included young married women aged 15-24 who had at least one live birth in the three years preceding each survey.	The use of full ANC and SBA increased from 1992-2016 in both India and Empowered Action Group (EAG) states. Still, the use of the full cycle of antenatal care was below acceptable. There were also people who had significant differences based on the maternal age, residence, education, religion, and socioeconomic status, with significantly lower utilization seen among the economically disadvantaged groups.	This paper will fill the gap in research, which pays specific attention to the issue of young married women aged 15 to 24 years in India, and will determine whether they use maternal health services. It provides a detailed discussion of trends in time and the determinants within a span of more than 20 years.	Maternal health care, Antenatal care, Skilled birth attendance, Young women, India, NFHS, Pooled data.	BMC Pregnancy and Childbirth, https://doi.org/10.1186/s12884-021-03607-w
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RESEARCH ARTICLE	The levels and trends of contraceptive use before the first birth in India (2015–16): a cross-sectional analysis	To evaluate how common and how varying the use of contraceptives before the first child birth is among ever-married Indian women aged between 15 and 34, and to identify which sociodemographic factors affect such a behavior.	This paper analyzed findings of the fourth edition of the National Family Health Survey (NFHS-4), which was conducted in the year 2015-2016, and compared them with previous editions (NFHS-1, NFHS-2, NFHS-3). The population size was 279,896 women who were ever married.	The use of contraceptive s before the first birth declined in NFHS-4 compared to previous surveys. The likelihood of use is significantly affected by residence, religion, caste, education, wealth, age at marriage, media exposure, and geographical zone. The highest use was in the eastern zone, and the lowest was in the southern zone.	The study addresses a lack of sufficient literature on contraceptive use before the first birth in India. It provides a comprehensive analysis of trends and determinants over a significant period, identifying key sociodemographic factors that influence this behavior.	Contraceptive, Ever-married, First birth, Logistic regression, Odds ratio.	BMC Public Health, https://doi.org/10.1186/s12889-020-08917-w
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REVIEW	Social determinants of maternal health: a scoping review of factors influencing maternal mortality and maternal health service use in India,(Hamal et al., 2020)	To map and summarize the evidence on social determinants influencing maternal health in India, and to understand the mechanisms of their influence using a maternal health-specific social determinants framework.	A scoping review was conducted using articles from PubMed, Science Direct, and Google Scholar published after 2000. 41 studies were included in the final analysis, with 25 identified through database searches and 16 through reference checks.	Key structural factors include economic status, caste, education, gender, religion, and culture. Major intermediary factors include place of residence, age, parity, and media exposure. The health system emerged as a crucial independent intermediary factor. Structural factors influenced intermediary factors, leading to differential access to maternal healthcare.	The study addresses a lack of a systematic attempt to map the documented sources of maternal health inequities in India, moving beyond the limitation of previous studies that analyzed only five structural determinants. It highlights the need for further research on the framework and maternal health.	Social determinant s, Structural factors, Intermediar y factors, Maternal health, India.	Public Health Reviews, https://doi.org/10.1186/s40985-020-00125-6
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Original Research	Delivering an Integrated Package of Maternal Nutrition Services in Andhra Pradesh and Telangana (India),(Sethi et al., 2019)	To evaluate maternal spot feeding programs in Andhra Pradesh and Telangana, two states in southern India. The study aimed to assess the on-ground implementation, stakeholder perspectives, and the potential for improving the nutritional profiles of enrolled women.	The study collected primary data from 360 pregnant and lactating women in each state from July to November 2016. It also reviewed the scheme's management information system records from April 2014 to August 2017. Additionally, open-ended interviews with 252 program managers and an Open Space Technology workshop were conducted.	The program's spot meals enhanced dietary diversity and consumption of eggs and milk. While counseling was high, on-the-spot consumption of iron and folic acid tablets was low. The majority of beneficiaries were motivated to enroll by self-help groups and family members, and the scheme shows potential for integrating nutrition interventions.	The study is one of the few formal operational evaluations of a large-scale maternal spot feeding program in India. It highlights the need for further research on the scheme's impact on birth outcomes, maternal depression, social norms, and cost-effectiveness.	India, maternal nutrition, maternal spot feeding, pregnancy.	Food and Nutrition Bulletin, 10.1177/0379572119844142
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Original Research	Utilization of Institutional Maternal Delivery and Associated Factors among Rural Women: A Case Study of High Priority District of Himachal Pradesh,(Kaur, 2024)	To analyze the perceptions of rural women regarding the place of delivery in Lahaul and Spiti, Himachal Pradesh, through the Health Belief Model (HBM), and to identify risk factors and determinants of institutional maternal delivery.	A cross-sectional study was conducted in remote villages of Lahaul and Spiti, Himachal Pradesh, from April to May 2021. The study included 410 pregnant women, selected through a multistage random sampling method using a structured questionnaire.	56.1% of women chose institutional delivery, while 43.9% preferred home birth. Factors such as a high number of antenatal care (ANC) visits, higher education, economic independence, and believing in the severity of home delivery complications were associated with a higher probability of choosing institutional delivery.	The study addresses a research gap for the remote and high-priority Lahaul and Spiti district, where few behavioral models have been used to understand women's perceptions about institutional delivery. It highlights a need to improve health infrastructure and transportation in these areas.	Barriers and odds ratios, health belief model, institutional delivery, Lahaul and Spiti.	Indian J Public Health, 10.4103/ijph.ijph_900_24
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Table 3: Categories and subcategories as presented in the results.

Main Category (Thematic Finding)	Sub-categories (Key Components)
1. Perceived Medical Necessity and the Burden of Physical Health	Physical Health Indicators and Interventions: Objective markers (e.g., low height, anemia) driving acceptance of medical intervention.
	Conflict with Antenatal Expectations: Disappointment and emotional distress when ideal physical health adherence does not prevent provider-driven intervention.
2. Fear of Pain, Trauma, and the Preference for Predictability (Mental Health)	Elective CS as a Coping Mechanism: Opting for surgery for psychological safety, control, and to avoid feared trauma or abuse during labour.
	Past Trauma and Decision Avoidance: Deferring decision-making responsibility to others as a defense mechanism against re-experiencing previous psychological injury.
3. Erosion of Autonomy and Its Psychological Fallout	Coercion and Consent: Procedural interventions performed without adequate consent, resulting in feelings of powerlessness and violation of bodily integrity.
	Exclusion from Financial Decision-Making: Limited control over healthcare spending amplifies feelings of dependency and postnatal anxiety over financial security.
4. Physical Recovery Challenges and Subsequent Reproductive Decisions	C-section Recovery vs. Vaginal Recovery: Painful, prolonged physical recovery post-surgery hampering maternal duties and increasing anxiety about future pregnancies.
	The Anemia-Intervention Cycle: Physical markers initiate an anxiety-fueled cycle of intervention, strengthening the resolve to limit family size.

5. The Protective Role of Partner and Family Support on Mental Well-being	The Birth Companion Mandate: Companion presence acting as a crucial buffer against abuse, anxiety, and perceived abandonment.
	Spousal Communication and Decision Parity: Active participation by partners reduces anxiety, validates the mother's experience, and promotes shared responsibility.
6. The Infrastructure-Quality-Mental Health Nexus	Waiting Times and Anxiety: Long waits amplify fear and physical discomfort, leading to the psychological distress of perceived abandonment.
	Staffing and Respectful Care: Perception of rushed/indifferent providers resulting in feelings of fear and disrespect, acting as a major deterrent for future institutional care.

RESULTS

Qualitative synthesis of the gathered evidence material of the included studies results in a holistic and integrated narrative that helps explain the convergence of maternal mental and physical health variables to inform the process of birth

decision-making in the context of Tamil Nadu women. The approach combined the experiential information on a personal and a partner level, thus revealing the six interconnected thematic areas.

Table 4. The Included Qualitative Studies Characteristics.

The table above provides contextual details regarding the main evidence included in this review, thus clarifying the extent and the focus of the studies adopted in the analysis.

Study (Key Citation)	Location & Sample	Focus	Main Contribution to Review
Dögg et al. (2025)	Multi-India (16 qualitative studies)	Women's general birth experiences, quality of care, and abuse.	Provided broad thematic findings on disrespect and fear of labour pain as non-clinical drivers of choice.
Gummadi et al. (2024)	Tamil Nadu (680 primigravidae women)	Association of maternal height (<150cm) with delivery mode and outcomes.	Identified a crucial physical health predictor (short stature) linked to increased risk of CS, framing the concept of <i>medical necessity</i> .
Dixit et al. (2025)	South India (NFHS-5 subset)	Influence of older women's choices on younger women regarding elective CS.	Established intergenerational choice patterns and high CS rates as a phenomenon linked to social influence.
Alelign et al. (2024)	Ethiopia (PCMC data)	Person-Centered Maternity Care (PCMC) scoring and staff-patient interaction.	Provided comparative insight into the global impact of poor communication and low PCMC scores on patient experience.

1. Fear of Pain, Trauma, and the Preference for Predictability (Mental Health)

One of the most prevailing factors in non-clinical decisions on birth was the deep-seated feeling of fear and the very strong tendency towards the development of an orderly, earliest delivery. This fear did not end in physical pain; it, in a very critical sense, included the fear of possible psychological trauma that may result in being neglected or abused in unpredictable public labour.

The respondents explained their Cesarean experience as a controlled and safe option, instead of a medical necessity, as it was one of the ways to avoid humiliation and pain (Dogg et al., 2025).

Planned cesarean section has been reported as part of coping, particularly when dealing with women who belong to higher socioeconomic classes, and thus they can avoid the emotional danger of unassisted vaginal births as well as the perceived risk of disrespect (Dixit et al., 2025). This propensity to

psychological security has cemented the choice of surgical predictability, such that it is therefore not surprising that cesarean section has been chosen over gestational physiological recovery.

2. Erosion of Autonomy and Its Psychological Fallout

The analysis found a direct relationship between the loss of control in clinical settings and serious psychological distress. They always detailed that an intervention done against their wishes was a breach of bodily integrity.

- **Coercion and Consent:** Women had always described situations where no procedures, like augmentation and episiotomy, were done without clear explanation or explicit consent. Not only was such an occurrence perceived as an informational deficit, but also as a form of violence, which created the feeling of powerlessness. This

disenfranchisement significantly led to an adverse birth experience and postpartum panic.

- **Exclusion from Financial Decision-Making:** Even though women were generally more educated, they were still not allowed to have control over their healthcare expenditures (Mondal et al., 2020). Choice not to take the free public care and to spend money on expensive private facilities in cases of an emergency were often family-mediated and thus created the dependence complex in the woman, increasing the postnatal fears about money security.

3. Perceived Medical Necessity and the Burden of Physical Health

A change in decision-making authority often occurred as a result of an objective physical health indicator and shifted control out of the hands of the woman and into the hands of providers, although they still bore the same psychological burden.

- **Physical Health Indicators and Interventions:** Such objective factors as a maternal height of less than 150 cm (Gummadi et al., 2024) and chronic anemia have continually been mentioned as indicators that should request proactive provider interventions. Most women felt that these interferences were inevitable, and thus they changed their fear of having a difficult labour to a psychological need to undergo surgery.
- **Conflict with Antenatal Expectations:** These women who followed the specifics of the anti-birthing protocols often stated that they were disappointed and emotionally shot down when the small signs of something serious still led to taking action (Singh et al., 2021). This discrepancy of hard work, or strict following of care guidelines, and failure of unassisted birth preconditioned the feeling of self-censorship and insufficiency during the postpartum.

4. Physical Recovery Challenges and Subsequent Reproductive Decisions

The length and intensity of the physiological recovery turned out to be the crucial factors that preconditioned the long-term reproductive choices and directly defined the connection between the birthing experience and further mental and somatic health decisions.

- **C-section Recovery vs. Vaginal Recovery:** The recovery period after cesarean section was always reported to be more painful and restraining, thus hampering the maternal roles. The use of this painful physical procedure had a significant impact on the contraceptive decision-making of women who favored the adoption of restrictive contraceptives like sterilization or the introduction of longer birth-spacing intervals (Rana et al., 2019a) because the

prospect of a new surgical recovery was considered unbearably dangerous.

- **The Anemia-Intervention Cycle:** The antecedent predictors of repeated medical surveillance identified included chronic physical conditions with noteworthy identification of anemia, which caused the anticipatory anxiety, which predetermined further pregnancies. The resulting psychological health burden in turn strengthened the psychological determination by the individual not to have many family members, and this prevented them from further being exposed to physical and mental tensions.

5. The Protective Role of Partner and Family Support on Mental Well-being

The active support systems have also been found to be a key protective factor, which has a significant impact on the confidence level of a woman and the character of her experience in the sphere of institutional care.

- **The Birth Companion Mandate:** The availability of a companion, an activity that is commonly accepted in Tamil Nadu units, served as the strongest regulatory aspect against the reported abuse and anxiety. The companion acted as an advocate, provided emotional support and a sense of security, hence leading to significantly increased chances of positive birth outcomes despite clinical intervention being justified.
- **Spousal Communication and Decision Parity:** In cases where partners were open and took into consideration the physical and psychological needs of the wife, women said that they felt much less anxious and experienced greater validation. It was a collective responsibility, which minimized self-blame and positively affected the postpartum mental health of women (Mondal et al., 2020).

6. The Infrastructure-Quality-Mental Health Nexus

The immediate environment and the quality of relationships exerted a powerful, direct impact on the mental health of the birthing woman, therefore producing her satisfaction with the safety of institutions.

- **Waiting Times and Anxiety:** Long queues in social hospitals were the major causes of hassles, fanning the fears and developing a strong sense of alleged abandonment (Alelign et al., 2024). As a result, this level of psychological distress also often forced women to take the initiative to seek private care, and in that way, place the issue of responsiveness of the staff at a high priority without considering affordability.
- **Staffing and Respectful Care:** The female population said they felt fear and disrespect by the providers, which is manifested by mental health damage, when the provider was thought to be

rushed, overworked, or indifferent (Ferede et al., 2022). Such an impression of inferior interpersonal contact surfaced as a key discouraging factor to consider attending public institutions in the future, thus demonstrating that the standards of healthcare are essentially pegged on the parameter of psychological safety.

The fundamental stories revealed the hierarchy of need, the psychological need hierarchy, in which emotional security and perceived respect ranked higher than long-term entreaties of physiological need. A fear of vagueness, the dilution of informed consent, and the need for help in negotiating the institutional fears were a consistent key element in thematic analysis.

DISCUSSION

The analysis of qualitative evidence that has been synthesized concludes that essential physical health risks and subjective needs for psychological safety have a strong and dynamic in Tamil Nadu maternal birth decision-making. Such understanding goes beyond traditional models, which were based on quantifiable clinical/socio-demographic determinants, thus anticipating the importance of the birthing woman's inward emotional landscape, which is so vital yet often overlooked.

Interpretation within Psychological Theory: Autonomy, Control, and Trauma

The results highlight how the choice of women in pregnancy is characterized by deep cognitive and affective appraisal, and not just the medical need. The given process can be successfully explained in terms of psychological theory, especially when referring to the premise that human need autonomy and control.

Self-determination theory (SDT) describes autonomy as an implicit psychological need that is a requirement for well-being.

The thematic conclusion of Erosion of Autonomy that includes the use of measures without the real agreement, the shutting down of patients to make any financial decisions, and the lack of effective communication is are direct deprivation of this need.

This deprivation creates the impression of powerlessness and violation (Dogg et al., 2025) and is temporally before the validated rise in post-natal anxiety and mistrust of institutional care.

As a result, the clinical environment, which is supposed to be a healing place, turns into an unwanted locus of psychological damage as long as the autonomy is stifled.

The rationale to undergo surgical treatment is direct psychological distress. The fact that many women choose cesarean section as the theme of Fear of Pain, Trauma, and the Preference of Predictability, attempts to encapsulate, might be in turn interpreted as a coping strategy aimed at the restoration of power perceived after an environmental assessment has apparently established that the environment

can be considered a threat. This choice is an active avoidance process where predictability of surgical trauma and postoperative recovery, which is considered as a cost in its own right, is preferred to the uncertainty permeating the process and emotional risks that are foreseeable with spontaneous labour. The consequence of one trauma and the avoidance of decisions only serve to sustain this trend; by rendering themselves into an authoritative professional, women seek to mentally dissociate themselves via the birthing experience and, in this way, promote the survival of self-concept over the reduction of the physical morbidity. This critical cognitive appraisal, and not objective clinical risk, therefore, becomes the most dominant factor behind the non-clinical preference to deliver by surgical section.

Comparative Insight Across Global Contexts

The psychosocial issues identified in Tamil Nadu are not isolated; they represent the systemic dysfunction of Person-Centered Maternity Care (PCMC), which can be demonstrated in other Low- and Middle-Income Countries (LMICs). The findings in question emphasize the prevalence of the problem in question and indicate the fact that the issues are not limited to a specific geographic context but rather indicative of larger-scale systemic shortcomings.

Comparative research carried out in several parts of Africa and Asia has shown the perceived disrespect to outshine clinical necessity as a decisive factor of care-seeking behavior. Literature tended to suggest that poor interpersonal communication and disrespectful behavior in health facilities may discourage expectant women from utilizing essential health services they need during pregnancy, therefore, increasing morbidity and mortality of mothers.

To take an example, perceived disrespect, which is a result of a lack of non-technical skills like communication, the inability to provide privacy, and a lack of concern in general, is identified in Ethiopia (Aleign et al., 2024), as well as Sri Lanka (Weerasingha et al., 2024), as a stronger predictor of dissatisfaction and preference for elective cesarean-section than actual clinical danger.

The poor scores of PCMC in the high-volume environment highlight the fact that a lack of simple human-centered care is a failure of a worldwide system.

The institutions in Tamil Nadu follow this trend: the large number of patients in institutions makes their staff focus on emergency medical procedures instead of empathy, which consequently creates negative conditions that patients feel are emotionally harming (Dogg et al., 2025).

The thematic finding of the Protective Role of Partner and Family Support is very important in this regard in the way of providing a very important comparative insight. Although the problem of institutional disrespect seems to be prevalent, a compulsory role of a prescribed Birth Companion often serves as a strong psychological cushion to reduce the effects of disrespectful care (Johansson et al., 2015). This implies that in an environment where systemic staffing reforms take time to be implemented, the process of empowering the social

unit by enforcing the Birth Companion Mandate would be a viable and practical in-between approach to enhance the psychological conditions of women. The analogy highlights the fact that the mental health safety net relies on both an instantaneous human bond and advocacy as much as it relies upon quality medical infrastructure.

Policy and Clinical Implications: Integrating the Health Nexus

Evidence synthesis clarifies the existence of obvious policy and clinical demand that requires mental and physical health indicators to be integrated into quality reform initiatives, thus overcoming the current indicator of maximizing the volume of cases within the institution (Ghosh & Ghosh, 2020).

1. **Trauma-Informed PCMC Implementation:** The existing clinical practice implies a clear shift of maternity care towards a trauma-informed and person-centered approach. This method implies the systematic management of all patients as potentially vulnerable, and with a specific focus on those exhibiting biodemographic risk factors, e.g., decreased maternal stature or chronic anemia (Gummadi et al., 2024) as antecedents of increased anxiety and perceived lack of control. Improvement of the quality of care presupposes the priority of informed consent in need of genuine consent, on the one hand, to all types of interventions in the operating room and the use of a comprehensive staff training focusing on respectful language and advanced clinical skills, on the other hand.
2. **Targeting the Bio-Reproductive Cycle:** Long-term reproductive counseling should be closely connected with the remediation of the physical health vulnerabilities. The article related to the Anemia-Intervention Cycle illustrates how the mode of delivery, specifically, the process of surgical recovery, influences future reproductive choice that serves to restrict the number of children (Rana et al., 2019a). Policy interventions should therefore reduce the amount of physical risk before the following pregnancy, and finally, women should be given sufficient physical/psychological recovery so that they can reduce the subsequent burden on the mind and minimize anxiety about the recurring intervention.
3. **Accountability through Psychological Metrics:** Maternal health quality policy evaluations need to be revamped so that psychological safety measures, including perceptions of perceived control, fear, and lack of explicit coercion, are directly placed on post-delivery surveys with the physical outcomes. This connection would soon be determining the psychological load of poor care and will hold the party responsible not only in terms of physical survival but also the entire psychological well-being of the woman.

The pursuit of psychological safety is a strong, independent source of birth decision-making, as evidenced. Incorporating this psychological need into the definition of quality, the Tamil Nadu healthcare system will be able to leave the process of reaching the institutional numbers to the actual promotion of maternal welfare, as well as offloading the non-clinical, omnipresent need to undergo a surgical operation.

Strengths, Limitations, and Future Directions

The given systematic review has a number of salient strengths. Mainly, it is the narrow scope of the synthesis of the qualitative data, within the high-institutional and, at the same time, complex configuration of Tamil Nadu, which provides it with an invaluable and unfiltered understanding of subjective experiences that are often mistakenly created with quantitative research. Psychologically combining the terms of the psychological theory, namely, control and trauma, with the biomedical risk factors, specifically, anemia and maternal height, this review provides a versatile framework that goes outside of the traditional determinants, thus shedding light on the true internal motives of birth decision-making. In addition, to ensure transparency and methodological rigor during screening and synthesis exercises, the compliance requirements with PRISMA 2020 guidelines are applied. However, there are various shortcomings that need to be noted. The non-English exclusion factor exposes the region to the danger of lacking the primary research, which is valuable and context-specific to the region. Results of the review are, per se, susceptible to interpretive subjectivity inherent in inductive synthesis and would be unable to eliminate the recall or social desirability bias of the original interview-based data. Importantly, the fact that no substantial quantitative studies are included, like NFHS surveys, hinders the possibility of estimating the prevalence of the identified psychological and physical barriers in the general population. Based on the current synthesis, this paper traces out critical areas of research to be done in the future. The longitudinal qualitative follow-up studies are highly needed to determine the changing patterns of maternal mental health, such as anxiety and posttraumatic stress disorder, in successive pregnancy launches and consequently on the long-term family-planning behaviors, contraceptive use, and postpartum birth spacing. Furthermore, the introduction of rigorous mixed-methods studies that explicitly involve quantifying clinical risk indicators (such as anemia rates or obstetric complication reports) and simultaneously analyzing the current qualitative data on the variables of psychological safety might provide a potent, context-specifically relevant source of evidence with regard to the suggested quality reform in the area.

CONCLUSION

The research paper concludes that the decisions made by mothers in Tamil Nadu are essentially a bargain between the physical health condition of the birthing woman and her ultimate requirement to be psychologically safe. The

continuation of the psychological obstacles, like previous trauma and expectation anxiety, can frequently be the reason why women decide to undergo planned surgical procedures (CS), perceiving them as the essential measure of defence against the affective risks of institutional labour in the open. The evidence has necessitated a holistic re-framing of maternal health that acknowledges that physical existence is not as crucial as mental well-being. Thus, implementation science based on the models of trauma-informed, person-centered care, with the explicit monitoring of the improvement in the maternal mental health outcomes (e.g., anxiety, depression, PTSD) as the main measure of the successful quality reform, should be prioritised in future research and policy.

DECLARATION OF COMPETING INTEREST

There is no conflict of interest for this research.

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