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Caesarean deliveries in Telangana State: Beliefs about maternity, awareness of institutional deliveries, and state interventions

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Abstract
The rising incidence of caesarean births in Telangana, especially those deemed medically unnecessary, constitutes a substantial public health issue. This study examines the social, cultural, and psychological factors that affect women's preferences for caesarean procedures, together with their knowledge of institutional delivery programs and state initiatives like the KCR KIT. Mixed methods were used, and the secondary data was abstained from Telangana's public health records, the National Family Health Surveys (NFHS-4 and NFHS-5), the District Level Household Surveys, facility surveys, and other government reports. Interviews with stakeholders, health officials, social activists, and other key informants provided contextual insights. Interviews were conducted with 40 pregnant women in Jagtial District who had received prenatal care and expressed a preference for caesarean delivery. The data were evaluated by content analysis, employing a systematic framework to identify themes grounded in socioeconomic and nutritional variables. The findings reveal that perceived safety, cultural beliefs, and timely circumstances were the predominant motivators for choosing caesarean delivery, followed by familial pressure, media impact, and previous negative birth experiences. Women's decisions were shaped by a blend of emotional, cultural, and informational factors, rather than solely medical ones. The study highlights the need to enhance maternal health literacy, antenatal counselling, and community education in facilitating educated, safe, and contextually appropriate birth choices.

Keywords: Caesarean births, institutional deliveries, maternity, social beliefs, women health, reproductive health

1. Introduction
Socio-economic factors are one of the many components that lead to the worldwide disparity in the availability of critical support and care for expectant mothers. Though the greatest efforts made by concerned public health departments as well as civil organizations, the majority of expectant and nursing mothers worldwide still struggle to receive the required attention and care. The social and economic standing of women and girls, their level of education, their diet, and the availability of family planning and health services within the community all have a direct impact on the outcomes of pregnancy. Recent developments in the medical sciences have had a major role in lowering the risks associated with childbearing. Despite these encouraging developments, there were about 810 women lose their lives globally in relation to pregnancy complications and childbirth emergency cases per day; about 94% of these deaths take place in underdeveloped nations (World Health Organization, 2019) [22]. At least 25% of maternal deaths reported worldwide have occurred in India, despite the implementation of numerous efforts aimed at promoting safe motherhood. India has come a long way in the last two to three decades in terms of economic improvement and programmes, but it is still far from reaching its target of fewer than 100 maternal deaths per 100,000 live births. Maternal mortality varies throughout states in India due to its large geographic area and diverse sociocultural population, and implementing health-sector changes consistently has proven to be difficult.
Interestingly, pregnancy and childbirth are conditions that exclusively affect women and may worsen existing health issues. However, there are ways to lower the dangers to one's health during pregnancy and childbirth by using competent birth attendance appropriately in conjunction with supportive emergency obstetric care. Maternal illness has serious adverse effects that extend well beyond the mother's condition during pregnancy and childbirth.

These outcomes may result in her demise, additional illnesses, or impairment during the protracted (up to a year) postpartum phase. These will negatively impact not just the family's social and financial standing but also the health of her unborn child.

Most women have some kind of issue during their pregnancy, delivery, or after giving birth, which leads to more difficulties, many of which might be potentially fatal and necessitate immediate obstetric treatment. Since 2000, the global maternal mortality ratio, or MMR, has dropped by 38% (World Health Organization, 2019) [22]. Additionally, according to the data, the global MMR dropped from 385 in 1990 to 216 in 2015. In 1990 and 2015, the MMR for developed nations was 23 and 12, respectively. Conversely, in emerging nations, the MMR dropped from 430 in 1990 to 239 in 2015. The statistics provided by the Registrar General of India (SRS-Statistical Report, 2020) indicates that India's maternal death rate decreased from 167 in 2013 to 113 in 2020 for per 100,000 live births. The country's growing institutional delivery percentage- which increased from 26% in 1992-1993 to 79% in 2015-16—could be the source of this 54-point drop in just 7 years (IIPS and ICF, 2017). Because of this success, India has attained the fifth Millennium Development Goal (MDG), which aims to reduce the country's mean monthly rainfall by three quarters between 1990 and 2015. Less than 70 deaths for every 100,000 live births is the target mortality rate by 2030, but this is still a long way off from being achieved, according to Sustainable Development Goal 3.1. According to UN MMEIG forecasts, in order to achieve this, nations such as India would need to lower their MMRs by at least 6.1% annually between 2016 and 2030 (United Nations *et al*., 2020) [4].

When compared to many developing nations with comparable or even lower income per capita, India's maternal and child health (MCH) care outcomes are regrettably appalling. Women are more likely to have serious maternal problems after childbirth and to die and suffer from morbidity in the postpartum period. The slow progress in reaching the MDG targets continues even after the Sustainable Development Goals (SDG) provided a fresh chance to witness gains in maternal health in all circumstances in 2015 (World Health Organization, 2018) [21].

The Indian government's early 2005 launch of the Janani Suraksha Yojna (JSY) and the National Rural Health Mission (NRHM) projects have significantly impacted the nation's overall use of maternal health care. Giving rural communities, especially the most vulnerable groups, access to high-quality, fairly priced healthcare is the main objective of these projects. Community health volunteers assist in facilitating and providing healthcare services like ANC care, diagnostic facilities, institutional deliveries, and other outpatient and inpatient care in the nation. Examples of these volunteers include accredited social health activists (ASHAs), an Indian village-level female health worker, and auxiliary nurse midwives (ANMs).

In addition, the project lowers the MMR, particularly in states with a high rate of maternal mortality, and offers financial incentives to ASHAs and expectant mothers in order to promote institutional births. Numerous scholarly works suggested that JSY had an impact on institutional deliveries (Gupta *et al*., 2012) [7]. There is evidence to show that the introduction of JSY led to an increase in institutional deliveries. However, given that maternal morbidities are still rising, it might not produce an MMR reduction to the same degree (Jain, 2010) [13]. Surprisingly, the alarmingly high number of caesarean births in India in recent years may have something to do with these growing morbidities among mothers. Despite the fact that caesarean sections are performed to treat obstetric emergencies, women frequently choose them over vaginal deliveries because of concern for potential problems for the mother.

2. Problem Statement and Objective of the Study

The rising trend of caesarean deliveries in Telangana State reflects a complex interplay of medical, social, and cultural factors that shape maternal health choices and outcomes. While institutional deliveries have increased significantly due to government interventions such as the KCR Kit and Amma Vodi schemes, which aim to ensure safe motherhood and reduce maternal mortality, this surge has coincided with a sharp rise in caesarean births. Many women, influenced by social beliefs, familial advice, and perceptions of safety and convenience, increasingly view C-sections as a modern and less painful mode of childbirth. However, this belief often overshadows medical necessity, leading to the normalization of surgical deliveries even in low-risk cases. Moreover, varying levels of awareness about institutional deliveries and their associated procedures contribute to decision-making patterns that are shaped more by social norms and healthcare providers' recommendations than by informed maternal choice. The state's proactive healthcare policies have undoubtedly improved access to medical facilities and maternal care, but they have also inadvertently reinforced institutional dependency, sometimes at the cost of promoting natural birthing practices. Therefore, understanding caesarean deliveries in Telangana requires a sociological examination of the intertwined dimensions of belief, awareness, and state intervention in shaping contemporary maternity practices.

3. Materials and Methods

Relevant data was gathered using a variety of techniques, such as a review of the literature, secondary data analysis from Telangana state public health records, and data from national program management information systems. Stakeholders, health officials, social activists, and other important informants in the study have all been interviewed to provide contextual insights. Secondary data sources include the National Family Health Surveys (NFHSs), Household Surveys (DLHS), facility surveys, national government publications, and websites were also sources of data. The 5th round of the NFHS (NFHS-5, 2019-2020) state-level fact sheets and the compilation of the fourth round (NFHS-4, 2015-2016) are the data used for this study (IIPS, 2020; IIPS and MoHFW, 2017) [11, 10]. The survey offers data on the major indicators of mother and child health, mortality, and fertility. From March 2023 to September 2023, through the execution of descriptive qualitative research tools, the study conducted in-depth interviews with 40 expectant mothers who have attended prenatal care in selected public and private hospitals in Jagtial District, Telangana and preferred caesarean delivery.

Data analysis was done using content analysis with themes derived through a systematic framework based on socioeconomic and nutrition parameters. Prior to analysis, the data was cleaned to ensure accuracy. Objectivity was

maintained by acknowledging the intention of this research during interviews, which helped minimize bias in interviews and interpreting participants responses.

4. Analysis and Results

The major findings of the study are organized around four key thematic areas. The first theme explores the reasons behind the rise of C-section deliveries, examining both medical and non-medical factors such as maternal preferences, institutional pressures, and changing perceptions of childbirth safety. The second theme focuses on government schemes in Telangana State, particularly initiatives like the KCR Kit and Amma Vodi, which were introduced to promote institutional deliveries and enhance maternal and child healthcare. The third theme assesses the impact of these schemes, highlighting their success in increasing institutional delivery rates while also noting unintended outcomes, including the surge in caesarean procedures. Finally, the fourth theme analyses C-section trends in Telangana State, presenting a detailed overview of their prevalence across public and private healthcare institutions and the socio-economic and cultural dynamics influencing these patterns.

4.1 Reasons Behind the Rise of C-Section Deliveries

The study conducted a thorough analysis of the reasons why mothers prefer caesarean delivery have been categorised into several groups. Out of 40 respondents, superstitious ideas about auspicious birth dates in families, fear of childbirth, safety concerns regarding perceived health risks, unfavourable experiences from previous births, favourable views towards caesarean delivery, and availability to skewed information on social media and other platforms are a few examples. The majority of women choose caesarean delivery for multiple reasons. Prior to their inclusion in the study, every participant provided written informed consent. Participants were carefully chosen in order to learn about their opinions and experiences with C-sections. They stated that their preferred method of delivery was a caesarean section. A guarantee of anonymity and confidentiality was given, along with an invitation to participate in the study. The reasons underlying pregnant women's preference for caesarean delivery were investigated through in-depth interviewing.

Births by C-section increased in India between 2015 and 2020. The percentage of C-section births is high in more than half of the Indian states. In the first round of NFHS-5, 2019-2020, Telangana had the highest percentage of C-section deliveries in India (60.7%), while Nagaland had the lowest (5.2%). Thus, a descriptive qualitative study was carried out in the Hyderabad city of Telangana state to investigate the reasons why pregnant women preferred caesarean deliveries.

Table 1: Thematic Analysis of Factors Influencing Caesarean Delivery Preferences

Statement	%
Families and elders often encouraged scheduling deliveries on astrologically “auspicious” dates or times, linking birth timing with luck and destiny.	65%
women feared labour pain and complications, viewing C-sections as safer, more predictable, and less painful	50%
Women with traumatic or complicated previous deliveries opted for caesarean this time to avoid emotional or physical distress.	65%
Exposure to social media, peer advice, and online narratives normalized or glamorized C-sections as modern and safe	55%
Family members, especially husbands and elders, played a major role in the final decision, often prioritizing convenience and control over natural delivery.	65%

Among the 40 respondents, fear and perceived safety (70%) had the greatest influence on caesarean preferences, followed by familial pressure (65%) and cultural views (65%). Other significant influences included media influence (55%) and poor past experiences (50%). These statistics demonstrate that women's delivery decisions are influenced not only by medical concerns, but also by a complex web of emotional, cultural, and societal factors.

Many people prefer C-sections because they are afraid of labour discomfort and are concerned about complications. As one respondent stated, *“After hearing so many stories about difficult labours, I didn't want to go through that pain. Surgery seemed safer.”* Cultural expectations also influenced choices families frequently pushed deliveries on astrologically fortunate days, as highlighted by a participant's remark: *“My mother-in-law wanted the baby born on a good day according to the priest, so the doctor fixed a C-section for that date.”*

Past delivery experiences significantly influenced perceptions of safety and control. Several ladies who had previously experienced problems expressed similar sentiments: “*My first delivery was painful and exhausting. I didn't want to take the risk again.”* Meanwhile, social media was increasingly altering perceptions of modern parenthood. As one woman stated, *“Instagram and YouTube videos demonstrated that C-sections are uncomplicated and recovery is quick. That influenced my decision.”*

Finally, familial pressure frequently trumped personal preference, demonstrating how childbearing decisions are socially negotiated rather than independently made. A participant observed, *“Everyone in my family felt surgery was better for the baby's safety, so I just agreed.”*

On the whole, the findings indicate that the increase in caesarean births in Telangana cannot be explained purely via medical or institutional lenses. It is inextricably linked to how women, families, and communities perceive safety, modernity, and cultural tradition, emphasising the need for increased maternal health literacy, counselling, and balanced public awareness.

4.2 Schemes in Telangana State

One of the significant measures that require to reduce maternal mortality are to ensure and assure institutional deliveries in the hospitals. On the other hand, home deliveries are associated with socio-economic and cultural factors, and they are becoming a major sociological reason for maternal mortality in Indian context. In many rural households, women tend to deliver at home due to the social determinants of health and there is an inordinate delay in receiving the healthcare facilities during emergencies. To

address this concern, the Telangana state has launched KCR KIT scheme on 2nd June 2017 to promote institutional deliveries in order to address the alarming trends of maternal mortality rates particularly among marginalized women. This scheme was also intended to prevent malnourishment among children. The Telangana state government has made encouraging safe institutional deliveries a top priority due to the high rates of infant and maternal maternity. An estimated 10.85 lakh beneficiaries accessed the programme in 2020-21, and a further 7.95 lakh recipients used it until November 2021. The Aadhaar based Mother and Child Tracking System (MCTS) software is used by the health workers to track women during all stages of pregnancy and post-delivery periods. The Kit consists of 16 items that are necessary to keep the baby warm and hygienic such as Mosquito net, Baby mask cap, Dress, Two towels, Baby napkins, Jonson's baby powder, Baby shampoo, Baby oil, Baby soap, Toys, Plastic buckets, and two sarees for mother.

As per the eligibility criteria for availing the benefits of the scheme, the woman should give birth in the government hospitals, and she is eligible to receive compensation for only two deliveries only. This programme aims to compensate the wage loss throughout the course of the pregnancy. Incentives are provided under the KCR KIT programme to both beneficiaries and front-line healthcare providers, such as Accredited Social Health Activists (ASHAs), in order to encourage institutional deliveries at public hospitals. With incentives being one of the sources of earning, the ASHAs ensure that they are with women during pregnancy period, and ASHAs take these women to government hospitals for institutional deliveries. ASHAs also take the child for immunization, and make the lactating other to seek health services from Anganwadi, primary health centres etc. ASHAs are given directions to identify the pregnant women and ensure them to enroll under the scheme. This scheme provides the financial incentives to the pregnant women who give birth to the child in the Government hospitals and Primary Health Centres (PHCs). Financial Assistance of Rs. 12,000 will be provided to the women for Baby Boy and Rs. 13000 for Baby Girl. This incentive is intended to make up for the time that women lost from work during their pregnancies and the postpartum period. However, this incentive measure is not given at once rather it is provided in installments, and the last two installments will be paid after vaccinating the child. There is a direct link with the Aadhaar card of the beneficiary, and the amount is directly deposited in the bank account of the pregnant women.

4.3 Impact of the KCR Kit

An effect of the KCR Kit programme that has been beneficial is the rise of institutional deliveries at government hospitals. Out of 29,20,906 institutional deliveries that have taken place since the launch of KCR Kit scheme, there are 16,14,207 deliveries taken place in Government hospitals which is close to 55.2% of total deliveries in the Telangana state (2017-2022). While the remaining 13,06,699 (44.7%) deliveries have been taken place in private hospitals. Telangana's MMR dropped by 43% in the last ten years, from 110 in 2010-12 to 63 in 2016-18. From 2015 to 2016 and 2019 to 2020, respectively, the National Family Health Surveys NFHS-4 and NFHS-5 measured the infant mortality rate (IMR), which fell from 27.7 to 26.4 (per 1000 live births). Both institutional birth rates (from 91.5% to 97%) and government hospital birth rates (from 30.5% to 49.7%) improved between NFHS 4 and NFHS 5. Incentive mechanisms play a crucial role in influencing motivation and health behavior of the pregnant women and their families towards admissions in government hospitals. The use financial incentives have become a strategy to cultivate and motivate healthy behavior among the people which has become routine practice in India over the years now. An adequate and sufficient financial incentive can influence the discrete behavior of the individuals; however, these incentives serve up to short run, and they alone cannot address all issues and challenges linked with health seekers and health providers.

4.4 C-Sections in Telangana State

The rise in Caesarean deliveries was highly correlated with both biological and socioeconomic factors. There is a widespread perception that women from rural areas have lower rates of C-sections than women from metropolitan areas. However, this has been proved otherwise in the context of Telangana state. With the implementation of schemes such as KCR KIT, the number of institutional deliveries among the poorer women has been increased, however, majority of those institutional deliveries in the government hospitals were caesarean deliveries. This is one of the major concerns in the public health where the state sponsored schemes were directly and indirectly influencing for the growth of caesarean deliveries under the carpet of institutional deliveries.

Over time, caesarean sections (C-sections) pose a major risk to the health of mothers. The World Health Organization (WHO) states that a caesarean section can be performed in emergencies in order to save the lives of mother and child. Therefore, the process needs to be limited to complex pregnancies (Betrán et.al, 2017) [3]. Over time, caesarean sections (C-sections) pose a major risk to the health of mothers. In order to deliver the baby, a Caesarean delivery requires cutting the mother's abdomen and uterus. On the other hand, C-sections are prevalent in developed countries and, this tendency is developing in developing nations as well. The World Health Organization (WHO) recommended caesarean section only during emergencies and they can be performed for medical reasons for saving the lives of mother and infants. The shockingly high C-section rates in India compared to the WHO standard of 15% pose serious public health issues.

Some of the factors that have contributed to this increase include maternal requests, reimbursement systems, financial incentives, and the policies that encourage repeat caesarean sections.

The National Family Health Study (NFHS-4) conducted in India found that 17% of live babies were delivered by caesarean surgery. Additionally, 45% of C-section deliveries were scheduled after labour pains began, according to the NFHS-4. Additionally, 45% of C-section deliveries were scheduled after labour pains began, according to the NFHS-4. For the past ten years, this has climbed by about 9%. From 2015 to 2020, there was an increase in C-section births.

Over 50% of the states in India have high rates of C-section deliveries. In the first round of NFHS-5, 2019-2020, Telangana had the highest percentage of C-section deliveries (60.7%), while Nagaland had the lowest (5.2%).

It is generally understood that caesarean sections are only performed when pregnancy difficulties arise. Contrary to this popular belief, the findings of the study show that women with little or no difficulties are increasingly having caesarean sections performed. It has been found that women from higher social groups, with higher levels of education, and those residing in urban areas of Hyderabad city accept and undergo caesarean sections.

Numerous studies have shown that mothers who are obese have a higher likelihood of delivering their babies via caesarean section (Srivastava *et al*., 2020) [19]. Most of the respondents have shared about the knowledge about C-sections that the substantial risk factors can put the health of the foetus at risk and result in an unsafe vaginal birth. Among them were biological problems (obesity and advanced age), infertility, and even the mother's diabetes mellitus-related notion of having a large child. They believed that the baby would suffer harm because they might not have the strength to force the baby out due to their illness. A number of risk factors, such as age, infertility, medical issues, and the mother's perception of a large baby, have led to the decision of other respondents to have a caesarean delivery. Most women who underwent caesarean sections spent six days or longer at the hospital. Nonetheless, ladies who gave birth vaginally chose to return home sooner. In a way, the expenditure on C-Sections is higher when compared to the normal deliveries. Treatment for birth-related problems requires prompt postnatal care for both the mother and the child. The length of a woman's stay following childbirth is closely correlated with the provision of pertinent information to the mother about self-care and infant feeding.

The study revealed that the pregnant women were also strongly impacted by prior bad birth experiences. Women who have had traumatic births fear giving birth in the future because they think it would be harmful to both them and their unborn child. Another issue is inadequate analgesia throughout labour, which can lead to anxiety of pain during delivery. Many women felt that caesarean deliveries were preferable to vaginal births because they were more convenient, and didn't cause labour agony. Compared to vaginal birth, caesarean sections are believed to have been a safer technique with less blood loss and less excruciating agony. Sometimes, women who had fibroids also wanted to have them removed during a caesarean delivery.

The term “muhurt C-sections,” which is rapidly gaining popularity because “muhurt” in Sanskrit refers to a fortunate time, describes a larger trend in India where tens of thousands of women are choosing to have surgical caesarean sections in the hopes of giving birth on a date and time that their astrologers have deemed fortunate. In addition, the C-sections surgeries that were formerly limited to emergency cases and high-risk pregnancies are now being used as a common substitute by women who wish to avoid the discomfort and resume their careers sooner. Indians from middle-class and upper-class backgrounds, who have access to some of the greatest medical care available worldwide, are increasingly choosing this particularly treatment. One of the many justifications given by the respondents for choosing C-sections was that the families had pressured the doctors to do the procedure so that the kids would be delivered during a specific auspicious hour, or ‘muhurthams’. Seconds are used to indicate the time. It has become a new trend catching up fast with the expectant mothers and their families. Few expectant mothers were also insisted the doctors for deliveries in the seventh month of pregnancy in order to meet the timings for auspicious periods. Nonetheless, the physicians stated that caesarean sections were only done when the infant was safe and fit enough to meet the standards of medical urgency. The women respondents have learned the benefits of C-Sections through the social media, and from family and friends. Their selections may have been influenced by personal resources such as comments, experiences, or guidance from friends or family regarding their favourable or unfavourable birth experiences. This could potentially impact the decisions made by women. The traditional beliefs and practices are putting the health of the women and new born children at risk. Paradoxically, increased access to healthcare, education, and knowledge of the advantages of institutional births and C-sections can be largely credited for the rising number of C-section deliveries.

5. Discussion

Majority of the institutional deliveries that have been taken place in the government and private hospitals in Telangana state were caesarean deliveries. Many things, such as a woman's culture, prior experiences, interactions with medical professionals, and fear of pain during labour and delivery, can affect her readiness to undergo a caesarean section delivery. Women who preferred caesarean birth gave several explanations. The numerous reasons for selecting caesarean sections were identified by this study, including biased knowledge about C-sections, superstitious beliefs about auspicious birth dates, fear of giving birth, safety concerns during delivery, bitter experiences with the previous births, and more importantly they have a positive attitude towards caesarean birth.

5.1 Effects of C-Sections

There are various studies argued that caesarean birth is linked to poor new-born outcomes, such as weakened respiratory and gastrointestinal systems and mortality (Gondwe *et al*., 2020) [6]. Postpartum problems are more common after caesarean deliveries than after vaginal births, and most of them are linked to obesity (Loverro *et al*., 2001) [17] Symptoms such as swelling, dizziness, visual abnormalities, perspiration, and restlessness were warning signs of preeclampsia among the pregnant women. Remarkably, diets heavy in fat, salt, and fried meals were identified as a contributing factor to the development of pre-eclampsia. Positive attitudes on caesarean birth have a big impact, and this could be related to low health literacy. Women were grateful for the ease, speed, and lack of agony associated with caesarean delivery. Unaware of the potential for major difficulties in subsequent pregnancies, some respondents thought the treatment was safe. The choices among women about C-sections were largely impacted by the social and cultural milieu of their households. Numerous studies have demonstrated a correlation between the incidence of C-sections and mother and child mortality in low-income nations where a sizable fraction of the population lacks access to basic obstetric care (Hofberg, 2003) [9]. Living a healthy lifestyle is essential to sustaining oneself, and when women get more obese owing to eating choices and a lack of physical activity, particularly in urban areas, they become more likely to give birth through caesarean deliveries. Furthermore, secondary infertile

women fear a normal delivery because it could mean losing their opportunity at a live birth (WHO, 2010; Kirchengast and Hartmann, 2018) [16]. Research suggests that high C-section rates may have negative consequences on the health of the mother and child. C-section rates over a specific threshold have not been shown to provide any significant benefits for the mother or child. In comparison to vaginal delivery, maternal and neonatal mortality rates were increased with caesarean section (Chongsuvivatwong *et al*., 2010; Kamilya *et al*., 2010) [5, 14].

It is a misconception among women who have never given birth that a C-section is painless. It takes months and even years to recover for mothers and also the babies from the complications of C-sections. In certain cases, a caesarean section can save the lives of both moms and new-borns. Yet, it may result in unfavourable effects for the mother and the foetus (Kheir *et al*., 2016) [15]. Women who had had one prior caesarean delivery and those who had had several caesarean deliveries without labour were more likely to experience uterine rupture. It has also been reported that doctors were performing caesarean sections for time management and financial benefit without any medical rationale. It is no secret that a C-section delivery is more expensive than a normal birth. Without a doubt, a caesarean delivery is more expensive and requires less time and effort than a typical vaginal delivery (Basu *et al*., 2012) [2].

6. Conclusion

There is a widespread perception that women with higher education levels were more likely to have caesarean sections than those with lower education levels. With the implementation of schemes such as KCR KIT, the number of institutional deliveries among the poorer women has been increased, however, majority of those institutional deliveries in the government hospitals were caesarean deliveries.

The findings of the study argue that increasing women's literacy alone won't be enough to lower the number of needless Caesarean deliveries. In order to increase social and health awareness and educate the public, maternal and child health literacy must be provided in addition to general education and public health discourse. To discourage home deliveries, the state government of Telangana are encouraging pregnant women for institutional deliveries. However, the promotion of institutional deliveries alone is not sufficient to address health crisis among women. There is a need to discourage C-section deliveries in the hospitals. Community health providers, women, families, and society at large need to be educated about the significance of normal deliveries for pregnant women. The post-partum health effects of routine deliveries among healthy moms require greater public awareness. It is crucial to provide appropriate advice during antenatal care for women who are afraid of giving birth, such as analgesics for pain management and the advantages and disadvantages of vaginal and caesarean delivery. One's opinions or beliefs may be shaped by information gleaned from the media. Individuals differed in how they perceived and interpreted things based on their logic, experiences, and convictions. False information can propagate through one-way communication. Therefore, obstetricians should enlighten expectant mothers about misconceptions or false notions. Women's attitudes on the manner of birth may be changed and the number of on-demand caesarean births could decline if they had access to accurate, professional, and educational information.

Along with women, their families and the community should be more informed and educated about maternal health, and the side effects of C-sections on the mother and child. In order to increase maternal health literacy among women, the government should prioritize educating the public about the significance of routine births for healthy expectant moms. The frontline health workers are the main source of initial contact at the community level for providing services such as prenatal care, regular health check-ups, and other medical services for maternal and child healthcare. These frontline forces must be educated about the health complications of C-sections for mother and new born. Once they receive a proper health training, they will educate the local communities and families about the importance of natural deliveries. The primary care physicians can educate mothers about normal deliveries and their medical consequences during these check-ups, empowering them to make an informed decision.

Superstitious ideas about auspicious birth dates emerged as a remarkable cause in our study. Certain individuals hold fervent convictions in destiny, wherein their life path is predetermined by their date of birth. They would have terrible luck all their lives if they were born in an inauspicious time and hold strong astrological beliefs. If there is a moment when giving birth is auspicious, parents would choose that time because they want to give their kids the greatest chance possible. In addition to educating people about the negative effects of elective caesarean delivery on mothers and their unborn children, addressing personal beliefs and ideologies should be taken into consideration while designing and implementing healthcare policies for women and child.

There is a need to raise awareness of the value of a normal birth through various campaigns and social communication channels. Thus, it is imperative to create a mandate and public health decision specifying that caesarean sections can be performed only when there is a medically advisable in government and private hospitals, and to put the mandate into effect in the state of Telangana where the rate of caesarean sections is excessive.

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