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Ancient Indian Knowledge Systems of Maternal and Child Care and Their Application to Healing Architecture: A Narrative Review and Design Framework for Mother and Child Care Hospitals

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Abstract: ***Postpartum depression, anxiety and psychosis affect roughly one in seven mothers worldwide and impair bonding, breastfeeding and child development, yet mother and child care hospitals are still planned mainly around clinical efficiency. India's Vedic, Ayurvedic, Siddha and Yogic traditions have long held that the mother's mind, diet, conduct and surroundings shape her own and her child's well-being, but these traditions and hospital design rarely meet. This paper joins two strands. The first is a narrative thematic review of five documents on ancient Indian maternal and child care, coded against the continuum of care from preconception to childhood and appraised against current guidance and ethical norms. The second is a structured review of 50 peer-reviewed studies on care models, healing environments and social determinants of postpartum mental health. The traditions converge on continuity of care, the mother–infant dyad, the primacy of the mother's psychological state, family support and developmental staging, but they disagree on the timing of rites and contain practices that are unverified or unacceptable, including sex-selective rites, prelacteal honey and ghee, and supernatural aetiologies. A three-tier appraisal separates low-risk practices to support (Tier A), those needing study (Tier B) and those to set aside (Tier C). Modern evidence is strongest for keeping mother and baby together and for social support, and weaker and more indirect for architectural features and traditional practices. Carrying only Tier A and B elements forward, the paper derives seven design parameters and eight supportive spaces, including quiet, sound and mindfulness spaces offered as a choice, and sets out a case-study and interview programme to test them. The framework gives architects an evidence-informed, culturally grounded basis for mother-centred hospital design and treats tradition as a source of testable hypotheses, not clinical proof.***

Key words: Garbh Sanskar, IndianKnowledge Systems,Ayurveda, Siddha medicine, samskara, sattva.

1. INTRODUCTION- The postpartum period brings major physical, emotional, psychological and social change. Postpartum depression affects roughly 10–15% of mothers worldwide, and prevalence rises to about 40% among mothers whose infants are admitted to a neonatal intensive care unit (NICU) [1]; the burden is reported to be higher in low-resource settings [2,3]. These disorders disrupt bonding, impair breastfeeding and are associated with adverse outcomes in children [4–6].

Despite this burden, hospitals are typically designed around functional efficiency, infection control, bed capacity and staff circulation. Privacy, daylight, noise control, contact with nature, family presence and comfortable mother–baby interaction may be poorly addressed, and noise, overcrowding and restricted family access can add to stress, sleep disturbance and isolation just when rest and emotional recovery matter most. Healing architecture offers an alternative, treating light, acoustics, privacy, nature, materials and spatial organisation as influences on emotional comfort.

Ancient Indian thought reached a related view long ago. Care of mother and child is discussed in the Vedic samhitas, Brahmanas, Upanishads and Grhyasutras [7], in the Ayurvedic branch of Kaumarabhritya [7,8], in Siddha literature [9] and in Yogic prenatal education [10]. Under the name Garbh Sanskar, the tradition treats the womb as a sacred setting and holds that the mother's thoughts, feelings, food, speech and surroundings leave an impression on the growing child; it is now being re-examined alongside prenatal psychology and neuroscience [11]. The tradition is not uniform, however. Popular presentations often merge its strands and treat all claims as equally established, while sceptical commentary sometimes dismisses the whole corpus. Neither position helps clinicians, policymakers or designers who need to know which elements are well attested, which are consistent with current evidence, which are testable, and which are problematic. Hospital design, for its part, has seldom drawn on this material at all.

This paper contributes in three ways. It reviews and appraises the traditional knowledge critically instead of celebrating it; it consolidates clinical, architectural and social evidence that is usually reported separately and grades its strength; and it converts the combined findings into design parameters and a schedule of supportive spaces in which only appraised, defensible elements of the tradition are used.

1.1 Research gap- Six gaps are identified: insufficient focus on the prenatal as well as the postpartum stage; limited dedicated supportive spaces; an under-explored role of healing environments; insufficient integration of family support; insufficient integration of mother and child spaces; and little use of traditional Indian knowledge on maternal well-being in hospital design. A seventh, methodological gap

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

runs through the first: the traditional literature has seldom been appraised against current guidance before being proposed for practice.

1.2 Aim and objectives- Aim. To explore how ancient Indian knowledge of maternal and child care, appraised against modern evidence, can inform healing architecture that supports the prenatal and postpartum mental health of mothers in mother and child hospitals.

1. To describe how the Vedic, Ayurvedic and Siddha traditions conceptualise maternal and child care from preconception to childhood, and to identify their convergences, divergences and internal inconsistencies.
2. To appraise selected traditional practices against current guidance and ethical and legal norms, and to propose a tiered framework for their responsible use.
3. To identify the environmental and architectural factors that influence maternal stress, anxiety, comfort, privacy and emotional well-being.
4. To develop planning and design strategies that integrate healing and supportive spaces within mother and child hospitals, using only the appraised elements of the tradition.

2. Methodology- 2.1 Overall design; The wider study has seven stages: research papers; books and theory, including healing architecture, environmental psychology and Indian knowledge systems; case studies; user interviews; comparative analysis; design parameters; and supportive space requirements. This paper reports stages 1, 2, 6 and 7 and sets out the plan for stages 3 to 5 (Section 6). It is a narrative, qualitative synthesis of secondary sources. No primary clinical or field data were collected, and the aim is interpretive: to map, appraise and translate, not to estimate the effect of any intervention.

2.2 Part A: review of traditional knowledge: Sources were purposively selected to cover the major traditions and a contemporary integrative view. Five documents formed the corpus (Table 1). An AI-generated web-search overview was used only to identify leads and was not treated as evidence, because its claims cannot be traced to verifiable sources. The source documents were available as page images; each page was transcribed by optical character recognition and read in full, with the images consulted where the transcription was unclear. Content was coded deductively against five stages of the care continuum (preconception, antenatal, intrapartum, postnatal and neonatal, childhood) and inductively for cross-cutting themes, and discrepancies between sources were tabulated. Practices were then appraised against WHO antenatal and postnatal recommendations [12,13], Indian law on sex selection [14] and the quality of evidence offered in the sources themselves.

Table 1. Documents included in the traditional-knowledge corpus

Ref.	Source	Type	Tradition / focus	Evidentiary status
[7]	Bharathi and Prasuna, 2009, J Indian Med Heritage	Medico-historical review	Vedic, Brahmana, Upanishad, Grhyasutra; maternal and child care	Peer-reviewed textual survey citing primary texts
[9]	Arthi et al., 2022, Int Res J Ayurveda Yoga	Review article	Siddha antenatal, postnatal and paediatric care	Literature review; pharmacology inferred from studies not specific to pregnancy
[10]	Upadhyay, 2019, Renaissance (Sri Aurobindo Society)	Seminar report	Prenatal education: Vedic, Ayurvedic, Yogic (Kanchipuram, 11–12 April 2019)	Participant's summary of presentations; not peer-reviewed
[8]	Kapur, Indian Psychology Institute	Conceptual paper with a small empirical study	Ayurvedic paediatric texts and Dharmashastras; life-span view	Scholarly interpretation; preliminary data (n = 80)
[11]	Dixit, 2025, Archives Publishing (chapter)	Scholarly chapter	Garbh Sanskar, the Garbha Upanishad and Charaka Samhita, contemporary studies	Secondary review; empirical claims reported, not verified

2.3 Part B: review of modern literature: Modern literature came from a multi-step search of the Consensus database (Semantic Scholar, PubMed and other sources): 21 searches and one citation-graph expansion screened 230 papers, and after relevance filtering and de-duplication the 50 most relevant were retained. The principal studies are cited in the text. Findings were grouped into care models, the built

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

environment, and social and systemic determinants, and each key claim was graded for strength of evidence (Table 5).

2.4 Integration procedure: Traditional practices were carried into the design framework only if they fell in Tier A or Tier B of the appraisal (Section 3.7), and always as a choice offered to the mother. Tier C practices were excluded. The mapping from traditional concepts to spatial responses (Section 5.2) is this paper's interpretation and is marked as such; it is not a claim made by the sources.

3. Traditional Knowledge Across the Continuum of Care- 3.1 Conceptual foundations: Three ideas recur across the corpus. First, mother and child form a symbiotic unit: the diet, sleep, emotional state and social interactions of the expectant and nursing mother are held to shape the physical and psychological status of the infant [8]. Second, health is multifactorial and holistic, arising from inherited predispositions (doshas and gunas), environment, diet, season and developmental stage [8]. Third, ritual is an educational and social technology: the samskaras preserve and transmit knowledge as a convergence of ritual, philosophy and science [10].

Ayurveda is regarded as an upaveda of the Atharvaveda, which among the four Vedas deals most with conception, fetal development, labour and childcare [7]. The classical compilations of Charaka, Sushruta and the two Vagbhatas are some 1500–2000 years old, and the Kashyapa Samhita is devoted wholly to the care of children with the expectant and nursing mother [8]. Ayurvedic accounts of supraja-janana (healthy progeny) name six contributing factors: maternal, paternal and nutritional-environmental factors, which are open to conscious regulation, and constitutional, mental-karmic and spiritual factors [10]. Kapur frames the same duality as nature and nurture: gunas and doshas are nature, and the samskaras are socially sanctioned nurture delivered at developmentally appropriate stages [8]. Ayurveda's garbhini paricharya sets out month-by-month dietary, behavioural and ritual guidance to promote sattva, a state of clarity, virtue and emotional equilibrium in mother and child [11].

3.2 Preconception care: In the Ayurvedic texts care of the baby begins before conception: prospective parents are instructed in diet, ritual, conduct, psychological attitude and sexual practice through the rite of Garbhadhana [8]. Vedic sources stress the woman's tranquillity of mind and the fertile period (ritukala)[7]. The Grhyasutras describe spouse selection, abstinence during the first three days of menstruation and timing of intercourse, with windows that differ between texts and seminar accounts (the fourth to sixteenth day, or the fifth to sixteenth excluding the eleventh and thirteenth) [7,10]. Menstrual health is described as a mirror of reproductive health, and prenatal education is said to begin at puberty [10]. The Siddha tradition enriches adolescent girls' diets with black gram, fenugreek, jaggery and gingelly oil [9]. Several Grhyasutra selection criteria (a girl's name, hair, skin or number of friends) have no biomedical basis and are best read as social norms of their period [7].

3.3 Antenatal care: Embryology and the fetal mind. The Garbhopanishad gives a month-wise account of fetal development, from the head in the second month to the completion of organs in the eighth, with union of the embryo and jiva in the seventh [7]. Reviewers read the fetal coverings ulba and jarayu as vernix and amnion-chorion, but these correspondences are interpretive [7]. Via Charaka, consciousness emerges in the fourth month, the fetus is endowed with mind in the fifth, cognition dawns in the sixth, and the eighth month is critical because ojas is in flux for mother and child [8]. Kapur notes that although the specific faculties may not be scientifically valid, the assumption that psychological development begins before birth anticipates later findings on infant pre-wiring for cognition and language [8,15].

The garbha samskaras. Pumsavana, Garbharakshana (in some texts) and Simantonnayana belong to pregnancy, and the texts disagree on their timing (Table 2). Secondary sources disagree as well: Upadhyay places Pumsavana in the fourth month and Simantonnayana in the seventh [10], while Kapur places Pumsavana in the third or fourth month [8]; the total number of samskaras is given as sixteen in one source and seventeen in another [8,10].

Table 2. Reported timing of the prenatal samskaras across Grhyasutras

Samskara	Sankhayana	Asvalayana	Paraskara	Gobhila	Apastamba
Pumsavana	Third month (Pushya or Shravana)	Not described	Second or third month, before fetal movement	Beginning of third month	When pregnancy is evident (Tishya)
Garbharakshana	Fourth month	Not described	Not described	Not described	Not described
Simantonnayana	Seventh month of first pregnancy	Fourth month	Sixth or eighth month of first pregnancy	Fourth, sixth or eighth month	Fourth month

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

Source: [7]. Secondary accounts place Pumsavana in the third to fourth month [8] or fourth month [10], and Simantonnayana in the seventh month [8,10].

The stated purposes also vary. In the Grhyasutra and Vedic accounts Pumsavana aims at securing a male child by instilling herbal juice into the wife's right nostril [7], and Kapur notes that Garbhadhana and Pumsavana are steeped in a social preference for a male child [8]. The seminar report instead describes Pumsavana as fetal protection [10], showing how contemporary interpreters reframe a text whose stated purpose is problematic. Simantonnayana is described as conferring special status and the comfort of the maternal home on a woman who has carried a pregnancy past the period of highest miscarriage risk, promoting emotional tranquillity [8], or as satisfying cravings and keeping the mother happy [10].

Nutrition and protection. The Atharvaveda advises milk as fetal nourishment and identifies maternal nutrition and health as important to a good offspring; pregnant women are warned about raksasa and krimi in the dwelling that may cause abortion, stillbirth and neonatal death, with sunlight and yellow mustard as remedies [7]. Siddha antenatal care aims to prevent nausea, vomiting, constipation and anaemia and complications such as gestational diabetes, hypertension and pre-eclampsia [9]. The Siddha text Pararasa Sekaram prescribes ten month-wise herbal preparations, ground with milk, water or honey; one (month 6) uses rabbit bile [9]. The authors relate the plants to reported pharmacological activities and call for research to establish effects [9]. The Tamil Nadu government's Amma Magaperu Sanjeevi kit distributes selected Siddha preparations through pregnancy and the postnatal period [9]. The seminar report emphasises a sattvic diet and adequate hydration [10].

Psychological care and prenatal education. The strongest continuity across sources is the emphasis on the mother's mind. Jayaraman, reported in the seminar account, described seven preventive-therapeutic tools: emotional atonement; breathing practices and postures; positive sensory stimulation; meditation on inner light; never letting the mother feel dejected; reading and sharing inspiring stories; and management of sleep and dreams [10]. Hearing positive birth stories from experienced women may build self-efficacy, and family members are responsible for a cheerful environment [10]. In contemporary form these principles appear as mindfulness, mantra chanting, guided yoga, soothing music, uplifting reading, counselling and a seasonal diet, together with garbha-samvada, deliberate communication between mother and fetus to help the mother keep emotional stability [11]. Dixit links these practices with better maternal stress outcomes, fetal movement response and postnatal behaviour when paired with scientific prenatal care, and reports yoga and sound-therapy sessions in some government hospitals and proposed Garbh Sanskar training for Anganwadi workers and midwives [11]. These are reported findings from a secondary review, not results of controlled trials.

3.4 Intrapartum care: The Atharvavedic accounts describe labour in practical terms. Vata is identified as the important factor, delivery is expected in the tenth (lunar) month, and experienced women attending labour are advised to counsel the parturient to remain brave, happy and patient [7]. Attendants are also advised to dilate the birth canal and to rupture the membranes to hasten labour, and expulsion of the placenta after the fetus is described as normal [7]. Grhyasutra texts add ritual measures, including telling the woman that a male will be born [7]. Two points stand out for the present purpose. Continuous emotional support and reassurance from experienced women is a consistent theme and is compatible with contemporary emphasis on respectful, supportive intrapartum care [12]. The Siddha review asserts that yoga and pranayama reduce stress, help prevent perineal tears and support normal delivery [9], but offers no primary evidence, so this is a hypothesis.

3.5 Postnatal, neonatal and childhood care: Jatakarma is performed immediately after birth. In the Grhyasutra texts the father breathes on the newborn and gives honey and ghee, butter or similar mixtures, and Medhajanana (production of intelligence) and Ayusya (long life) rites are performed before the navel-string is cut [7]. The seminar report reads Jatakarma differently, as support involving the father's presence, cord cutting, immediate skin-to-skin contact and initiation of breastfeeding, likened to kangaroo care [10]. The two accounts should not be conflated: the textual detail describes feeding of honey and ghee, not breastfeeding, and the skin-to-skin reading is a modern interpretation. The Ayurvedic paediatric texts describe the newborn as exhausted by birth and advise anointing with bala oil, and describe in detail the characteristics of the mother or wet nurse and of healthy and unhealthy milk, which Kapur suggests deserve empirical study [8]. A seminar speaker advised against pressuring or judging the breastfeeding mother, because a stress-free mother is a prerequisite [10]. Siddha postpartum care introduces food gradually with preparations for appetite and uterine recovery, and Sathavari legiyam to increase milk secretion; infants receive Sei nei and Urai mathirai, a tablet rubbed with breast milk [9].

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

Kashyapa divides life up to sixteen years into the fetal (Garbhastha), infant (Balya) and child (Kaumara) stages, with developmentally graded diets and drug doses [8]. Kapur argues that the childhood samskaras, though socially sanctioned, coincide with developmental milestones, so that Namakarana marks a time for general examination, Nishkramana (fourth month) for visual fixation, response to sound and head control, Annaprashana (sixth month) for the first tooth and readiness for weaning, and Upanayana for fitness for education [8]. This is an interpretation; in particular, reading ear-piercing as active immunisation is speculative. The one empirical study grounded in this framework applied the Triguna Temperament Schedule to 50 normal and 30 psychiatrically disturbed children aged four to six, finding 26 normal children predominantly sattvic, 14 rajasic and 5 tamasic; the author cautions that the sample is small and that whether sattvic temperament protects against psychopathology remains open [8,16].

3.6 Comparative synthesis: Table 3 summarises how the strands address each stage. The Vedic and Grhyasutra sources are strongest on ritual timing, embryology and labour; Ayurvedic paediatrics on developmental staging, dosing and the mother–infant unit; the Siddha source on named formulations and their incorporation into a state programme.

Table 3. Comparative synthesis of stage-wise emphases

Stage	Vedic / Grhyasutra	Ayurvedic paediatrics and Yoga	Siddha
Preconception	Spouse selection; ritukala timing; tranquillity; Garbhadhana	Diet, conduct and psychological attitude of both parents; six-factor model of progeny	Adolescent diet: black gram, fenugreek, jaggery, gingelly oil
Antenatal	Pumsavana, Garbharakshana, Simantonnayana; milk diet; protection from krimi and raksasa	Progressive fetal mind; emotional tranquillity; family support; mantra, yoga, meditation	Month-wise herbal regimen; yoga and pranayama; Amma Magaperu Sanjeevi kit
Labour	Attendants counsel calm; dilation and membrane rupture; ritual aids	Not a focus in the accessed sources	Yoga and pranayama said to support normal delivery
Postnatal and neonatal	Jatakarma; Medhajanana; Ayusya; honey and ghee	Bala oil; wet-nurse and milk characteristics; graded feeding	Sowbagya chundi legiyam; Sathavari legiyam; Sei nei; Urai mathirai
Childhood	Namakarana to Godanakarman; rites by varna	Three developmental stages; samskaras as milestones; Triguna temperament	Urai mathirai for gastrointestinal and respiratory disorders

Sources: [7–11].

3.7 Tiered appraisal of traditional practices: Table 4 assigns selected practices to three tiers. The assignment is a judgement based on plausibility, potential for harm, availability of evidence and ethical standing, not a formal evidence grading, and should be revisited as evidence accumulates. Tiers A and B feed the design framework; Tier C does not.

Table 4. Tiered appraisal of selected traditional practices

Practice (source)	Tier	Assessment	Suggested stance
Nutritional preparation and menstrual-health education [9,10]	A	Plausible and low risk; consistent with the emphasis on nutrition and counselling in antenatal guidance [12]	Support; integrate into counselling
Family support, social recognition (Simantonnayana), positive birth stories, avoidance of maternal distress [8,10]	A	Aligned with a positive pregnancy experience [12] and with the protective effect of social support [17]; low risk	Support; evaluate as psychosocial intervention
Early skin-to-skin contact and unpressured breastfeeding, as read into Jatakarma [10]	A	Consistent with current postnatal recommendations [13]; the reading is interpretive, not the textual detail	Support on current evidence, not textual authority
Mantra, OM chanting, music, yoga, pranayama, meditation [10,11]	B	Relaxation effects reported by speakers and a secondary review; controlled evidence not presented in the accessed sources	Offer as a choice; study with validated anxiety and stress outcomes
Siddha and Ayurvedic month-wise	B	Pharmacology inferred from studies not	Pharmacovigilance

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

herbal regimens [9]		specific to pregnancy; safety in pregnancy, dose and quality not established; authors call for research	and toxicology first, then trials
Triguna temperament and gunas/doshas in child assessment [8]	B	Small preliminary study (n = 80); testable and culturally relevant	Replicate and validate
Milk quality and wet-nurse characteristics [8]	B	Hypothesis-generating; not evaluated empirically	Study lactation and infant outcomes
Pumsavana and other rites aimed at male offspring; sex determination by date or side [7,8,10]	C	Ethically unacceptable as sex selection; contrary to Indian law [14]; not supported by genetics, in which the paternal gamete determines chromosomal sex	Set aside; reinterpret as a fetal-protection rite where used [10]
Instillation of herbal juices into the nostril; unstandardised preparations [7]	C	No safety or efficacy evidence; potential harm	Do not recommend
Prelacteal honey, ghee or butter for the newborn [7]	C	Conflicts with advice on early exclusive breastfeeding [13]; honey is not recommended for infants under 12 months because of the risk of infant botulism	Do not recommend
Animal-derived preparations (rabbit bile, month 6) [9]	C	Safety data absent; ethical and acceptability concerns	Do not recommend without evidence
Graha, raksasa and krimi as causes of fetal loss and childhood illness [7,8]	C	Supernatural aetiology; the clinical syndromes described may map to recognised paediatric conditions [8]	Treat as historical; use modern diagnostics
Advice to limit ultrasound to two or three scans irrespective of indication [10]	C	Harm is speculative; WHO recommends at least one scan before 24 weeks [12]	Follow clinical guidance

4. Modern Evidence on Maternal Mental Health and the Care Environment- 4.1 Mother–baby care models: The strongest clinical evidence concerns care models that keep mother and baby together. In a French cohort of 869 dyads across 13 psychiatric mother–baby units (MBUs), two-thirds of women improved significantly by discharge [18]. Day-hospital models in Spain and Germany report similar gains [19–21], as does a U.S. safety-net partial hospital programme using trauma-informed, multigenerational group therapy [22], while a Barcelona home-hospitalisation programme offered an alternative to admission with low relapse at one year [23]. Most studies lack randomised controls, so causal claims need caution. The spatial lesson is that mothers needing psychiatric support should not be separated from their infants. In a descriptive study of 300 mothers of hospitalised newborns, those who saw, held and breastfed their baby within 30 minutes of birth had lower depression scores and higher attachment scores [24].

4.2 The built environment: Healing architecture in maternity accommodation uses natural elements and comfortable surroundings and can house activities such as yoga and therapy [25]. Postpartum women want privacy and personal preference respected and value meeting other new mothers, which reduces isolation [26]. In Malaysian clinics, small rooms and lack of privacy inhibited mothers from raising mental health concerns [27], while in Taiwan women who stayed in a postpartum care institution had lower depression scores than those discharged directly home [28]. During COVID-19, exclusion of supportive relatives was associated with depression, anxiety and post-traumatic stress symptoms [29] and appeared to alter bonding [30]. Privacy, layout and visiting arrangements therefore have psychological consequences.

4.3 Social and systemic determinants: Social support is a consistent protective factor across designs and cultures [17,31,32]. NICU hospitalisation is associated with more severe maternal depression and anxiety [33], and socioeconomic disadvantage worsens outcomes [2], which makes equity of access a planning issue. Ineffective decision-making during birth is linked to more postpartum mental health problems, with respect and control as key domains [34]; disrespect and abuse during childbirth is associated with higher odds of postpartum depression, rising with the number of mistreatment types [35], and a recent study reports a dose–response link [36].

Providers often lack psychological training [37], co-locating maternal and paediatric services improves screening and counselling access [38], and tele-mental-health centres in public hospitals have proved feasible where specialists are scarce [39].

4.4 Strength of the evidence: Table 5 grades the main claims. Evidence is strongest for care models and social support, and moderate or emerging for architectural features and traditional practices.

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

Table 5. Strength of evidence for key claims

Claim	Strength	Basis
Mother–baby units improve maternal mental health	Strong	Prospective cohorts in four countries [18,22]
Social support protects postpartum mental health	Strong	Observational, longitudinal and mediation studies [17,31]
NICU stay worsens maternal depression	Moderate	Cross-sectional, strong correlations [33]
Respectful, participatory intrapartum care protects mental health	Moderate	Meta-analysis of observational studies [34]; birth cohort [35]
Healing architecture improves well-being	Moderate	Conceptual principles, indirect observational support, no trials [25,28]
Garbh Sanskar practices support maternal well-being	Emerging	Secondary reviews and a seminar report, positive but varied findings, plus one small temperament study; no controlled trials [8,10,11]

5. From Tradition and Evidence to Design- 5.1 Positioning: The traditional material is used here as a source of design ideas and testable hypotheses, not clinical proof. Dixit treats Garbh Sanskar as an adjunct to modern obstetric care, to be used carefully and studied rigorously, and offers it as a low-cost, culturally grounded option for maternal education in line with the emphasis on Indian knowledge systems in the National Education Policy 2020 [11].

This paper takes the same position and adds a filter: only practices in Tiers A and B of Table 4 are translated into space.

5.2 Mapping traditional concepts to spatial responses: Table 6 interprets selected concepts for design. The mappings are this paper's interpretation, not claims made in the sources, and the last column shows where modern evidence already supports the spatial response.

Table 6. Traditional concepts, spatial interpretation and supporting evidence

Traditional concept	Spatial or programmatic interpretation	Modern evidence for the response
Sattva: clarity and emotional equilibrium [11]	Calm, clear, uncluttered, low-stimulus rooms and circulation	Privacy and calm settings [26,27]; direct evidence lacking
Ahimsa: non-violence in thought and action [11]	Respectful, non-coercive care; layouts that protect dignity and allow information and involvement in decisions	Respect and control in birth [34,35]
Ritucharya: seasonal routine [11]	Daylight, views and openings that let a mother sense the day and season	Framework only; to be verified
Garbha-samvada: mother–fetus communication [11]	Quiet zones for reflection and quiet communication with the baby	Emerging [11]
Simantonnayana: recognition and comfort of the pregnant woman [8]	Homely rooms, family rooms and peer lounges that confer status and comfort	Social support [17,29]
Mother–infant symbiosis; Jatakarma read as early contact [8,10]	Rooming-in, early-contact areas, mother–baby spaces	Mother–baby units and early contact [18,24]
Positive birth stories from experienced women [10]	Peer lounges and group session rooms	Peer contact reduces isolation [26]
Stage-wise garbhini paricharya [11]	Distinct prenatal and postnatal settings; programming that changes across pregnancy	None yet; hypothesis for case studies

5.3 Design parameters: The synthesis yields seven design parameters (Table 7). Privacy, nature, comfort, social support and mother–baby proximity draw on the reviewed papers. Acoustics draws on the traditional use of calming sound, and light on the healing architecture framework adopted here, so both need verification in the case studies.

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

Table 7. Design parameters for a mother-centred hospital

Parameter	Design response	Basis
Privacy	Single or small-cluster rooms; private counselling rooms; personalisable bedspace	[26,27]
Nature	Views of greenery from beds; accessible gardens and courtyards; natural materials	[25]
Light	Generous daylight; controllable, glare-free lighting supporting sleep	Framework; to be verified
Acoustics	Wards separated from corridors and services; quiet zones; soft music or chanting where mothers choose it	[11]; framework; to be verified
Comfort	Homely rooms; spaces for yoga, therapy, mindfulness and relaxation	[11,25]
Social support	Family rooms, visitor provision, peer lounges	[17,29]
Mother–baby proximity	Rooming-in, early-contact areas, mother–baby care spaces	[18,24]

The parameters work together. A private room helps little if it is acoustically exposed to a busy corridor, and a healing garden has limited value if a mother recovering from surgery and carrying an infant cannot see or reach it from her ward. Each parameter should therefore be tested against a mother's journey through the hospital, from arrival and consultation to rest, feeding, family visits and discharge.

5.4 Supportive space requirements:

Table 8. Supportive spaces and rationale

Space	Rationale
Counselling rooms	Private setting for screening, disclosure and therapy [27,37]
Relaxation and activity spaces	Yoga, therapy, mindfulness, mantra and music sessions, offered as a choice [11,25]
Healing garden	Calming natural setting open to mothers, infants and families [25]
Breastfeeding spaces	Private, comfortable provision, since depression can impair breastfeeding [4]
Family spaces	Keep partners and relatives present and involved [29]
Mother–baby and mother–child spaces	Keep the pair together, including during psychiatric care [18]
Social and peer spaces	Reduce isolation through contact between new mothers [26]
Quiet zones	Rest, reflection and garbha-samvada, the mother's quiet communication with her baby [11]

5.5 Planning and zoning implications:

- **Co-locate care.** Place maternal, paediatric and mental health services together to improve screening and access [38].
- **Plan the NICU for mothers.** Provide family, rest and counselling space beside the unit, given the higher burden among NICU mothers [1,33].
- **Support family access.** Circulation and security should enable family presence by default.
- **Distinguish prenatal and postnatal settings.** Garbh Sanskar begins at conception, so waiting and consulting areas should offer calm, distinct settings for each stage.
- **Design for equity and culture.** Put supportive spaces in public wards, and provide acoustically suitable rooms for low-cost, culturally familiar yoga and sound sessions [11,39].

6. Case Study and Interview Programme- Selected national and international hospitals will be analysed against seven criteria: postnatal wards and rooms; privacy; waiting areas; courtyards and gardens; mother–baby spaces; family spaces; and circulation and zoning. They will also be checked for space to practise yoga, music, mindfulness and quiet reflection. Voluntary, anonymous interviews with mothers will explore privacy, noise, light, nature, family presence, rest and which traditional practices they value. Comparing the two will confirm, refine or challenge the parameters in Table 7, especially for light, acoustics and the prenatal stage. The expected outcome is a validated set of parameters and a space programme that can be applied to a hospital design project, with each recommendation traceable to published evidence, observed practice or user experience.

7. Discussion- 7.1 Convergence between tradition and evidence: Despite differences in idiom, the traditions converge on five ideas: continuity of care from before conception through childhood; the mother–child dyad as a unit; the primacy of the mother's psychological state; the role of family and community in

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

sustaining her; and the calibration of care to developmental stage. These are broadly congruent with the modern findings that keeping mother and baby together and providing social support bring clear benefit, and with the contemporary language of a positive pregnancy experience [12,13]. Convergence is not equivalence, however: the traditional vocabulary differs and its evidentiary basis is weaker. The value of the tradition for design lies in the direction it points, toward calm, sattvic surroundings, gentle sound, mindful practice and family involvement, which healing architecture can express in space.

7.2 Textual variation: The corpus shows substantial internal variation: at least four different months are given for Simantonnayana (Table 2), fertile-window rules differ, and the number of samskaras is reported as sixteen in one source and seventeen in another. Contemporary presentations often smooth over these differences. Responsible use requires stating which text and which reading is invoked, and separating primary text from later interpretation. Several of the most attractive modern claims, such as Jatakarma as kangaroo care [10] and the samskaras as developmental screening [8], are interpretive readings and are marked as such here.

7.3 Ethical and legal considerations: Four issues deserve emphasis. First, the male-child orientation of Pumsavana and of the reassurance that "a male will be born" [7] conflicts with gender equity and, where translated into sex selection or determination, with the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 [14]. No space, programme or signage in a hospital should carry such elements. Second, many rites are performed by the husband or father with the woman as recipient, and samskaras vary by gender and caste [7,8]; spaces and programmes should centre the woman's autonomy and consent. Third, hospitals serve people of many faiths and none, so practices such as chanting and mantra must be offered as a choice, never imposed, and quiet and mindfulness spaces should be inclusive in form. Fourth, substitution is a real risk: presenting traditional regimens as alternatives to antenatal check-ups, skilled birth attendance or immunisation would endanger mothers and infants. Traditional and modern frameworks should be complementary.

7.4 Implications and research agenda: For architects and student designers, the framework changes the brief. Beyond counting beds and consulting rooms, the designer asks what each space will feel like to a tired, anxious or isolated mother, and whether her family, her baby and her privacy have been provided for. Orientation, adjacency and landscape are decided early, so this costs little at the planning stage but is expensive to correct after construction. The prenatal stage deserves particular attention: the clinical literature reviewed concentrates on the postpartum period, whereas the traditions treat conception and pregnancy as the start of care, and antenatal waiting and consulting areas are the first parts of the hospital a mother uses. Five priorities follow:

- **Field validation** of the parameters in Table 7 through the case studies and interviews of Section 6.
- **Psychosocial trials** of standardised Garbh Sanskar programmes (relaxation, music, yoga, group sessions) against validated measures of maternal anxiety, depression and birth experience, including whether the physical setting changes their effect.
- **Herbal safety:** pharmacovigilance, toxicology and pregnancy-specific review of the regimens in Section 3.3 before efficacy trials.
- **Temperament and development:** larger longitudinal studies of Triguna-based temperament [8].
- **Philology and co-design:** critical comparison of primary texts, and participatory design of counselling materials and spaces with obstetricians, paediatricians, Ayush practitioners, psychologists, ethicists, architects and women who have received care.

7.5 Limitations: Detailed patient data are restricted by ethics and confidentiality, and the number of case studies, live visits and surveys is limited by time and resources. The modern literature is mainly clinical and postpartum-focused, most care-model studies lack controls, and findings from psychiatric units may not transfer fully to general wards. The architectural evidence is indirect and observational. The traditional corpus is small and purposively selected, mixes peer-reviewed articles with a seminar report and a web text, and is secondary: primary texts (Charaka, Sushruta, Kashyapa, the Garbha Upanishad and Siddha manuscripts) were not consulted, and Garbh Sanskar claims come mainly through one chapter whose empirical findings are reported, not verified. Sources were transcribed from page images by optical character recognition, which may introduce errors in Sanskrit and Tamil terms. The tiered appraisal and the concept-to-space mapping are reasoned judgements, not formal evidence gradings. The parameters proposed are therefore evidence-informed hypotheses, to be refined through fieldwork.

8. Conclusion- Postpartum mental health disorders are common and consequential, yet the hospitals where many mothers begin recovery rarely respond to their psychological needs. Modern evidence supports

I S S N NO. - 2347 – 2944 (Print)
e–I S S N NO.- 2582 – 2454 (Online)
Vol.-20, No.- III, Issues-41, YEAR- July-Sept. 2026

integrated mother–baby care and social support, and indirectly supports privacy, nature, family and peer spaces. Ancient Indian knowledge adds a long-standing, culturally rooted view that the mother's mental state and surroundings matter from conception onward, but the same corpus contains statements that are unverified, internally inconsistent, or ethically and clinically unacceptable. Appraising the tradition before using it allows its strengths to be carried into design without its problems: low-risk psychosocial and nutritional practices are supported, promising but untested ones are offered as a choice and studied, and harmful ones are set aside. Mother and child hospitals should therefore combine healing-environment principles, mother–baby spaces, co-located services, private counselling and quiet, sound and mindfulness spaces. The seven parameters and eight spaces proposed here are a starting point that the planned case studies and interviews will test. A mother's psychological recovery is a design question as well as a clinical one, and architects share responsibility for hospital environments in which mothers feel safe, private, supported and close to their children.

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