

Cultural Myths Associated with Prolonged Labor: Consequences on Stillbirth in Ebonyi State, Nigeria

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Abstract

Problem: This study investigates the complex interaction between cultural beliefs, health-seeking behaviour, and the increasing rates of preventable stillbirths. The prevailing cultural belief system regarding pregnancy and the associated health-seeking behaviour among pregnant women have, unfortunately, contributed to a concerning prevalence of preventable stillbirths within society such as Ebonyi State, Nigeria. **Methods:** This study adopts a mixed-method approach, utilizing quantitative data extracted from the District Health Information System version 2 (DHIS2) and qualitative insights gathered through key informant interviews and focused group discussions. **Aims:** The research objectives aim to assess the prevalence of stillbirths in the region and cultural myths associated with prolonged labor, unravelling their impact on the persistently high rates of stillbirths. **Findings:** Findings from the study highlight the profound influence of cultural beliefs on pregnant women's health-seeking behaviour. Traditional Birth Attendant (TBA) places and homes emerge as preferred delivery locations due to their perception of the efficacy of TBAs. Additionally, religious doctrines and misconceptions about caesarean sections contribute to delays in health-seeking behaviour. **Conclusion:** The research accentuates the critical importance of understanding and addressing cultural factors in the design of interventions and policies aimed at reducing stillbirth rates.

Keywords

Stillbirths, Cultural-Beliefs, Myths, TBA

1. Introduction

The prevailing cultural beliefs and associated health-seeking behaviours among pregnant women have contributed to a concerning prevalence of preventable stillbirths in societies. Cultural myths are longstanding and unconfirmed cultural misconceptions about pregnancy and childbirth. These influence health-seeking behaviours of pregnant women and women in labor, which have consequences on pregnancy outcome, such as stillbirth. According to a study conducted in Zambia by [1], women, overtime have some common beliefs relating to diets, behaviour and local herbs, massaging pregnant women's abdomen during pregnancy and after childbirth.

Despite considerable technological advancements and the widespread availability of modern healthcare clinics in most communities, the persistence of stillbirth as a prevailing concern in some African nations is disconcerting [2]-[6]. WHO defined stillbirth as the demise of a baby either before or during delivery, occurring at or after 28 weeks of pregnancy. Stillbirth remains a poignant aspect of perinatal mortality experienced by women of reproductive age in low- and middle-income countries [7] [8]. Also, this mortality rate is likely to be higher in rural areas due to their low socio-economic status. [9] conducted a comprehensive study, which revealed that the following ten nations: India, Nigeria, Pakistan, Democratic Republic of the Congo, China, Ethiopia, Bangladesh, Indonesia, Afghanistan and Tanzania collectively account for more than 65% of global stillbirths. Regrettably, Nigeria is second in this ranking, grappling with a staggering 313,700 stillbirths in a single year.

Furthermore, the National Population Commission (NPC) [10] reports a disquieting upward trajectory in stillbirth rates. In 2013, the country recorded 396 stillbirths, a number that surged to 605 in 2018, reflecting a disconcerting 65% increase within five years [10] [11]. This not only emphasized the gravity of the stillbirth predicament, but also highlighted its significant impact on the demographic landscape of this pronatalist society.

Beyond mere statistical enumeration, the implications of stillbirth extend to all other sectors of the society. The increasing prevalence not only signifies a threat to individual reproductive health, but also poses a substantial obstacle to the overall population growth of the country. Furthermore, women of reproductive age living in rural communities are more vulnerable to stillbirths due to a variety of reasons. Given the gravity of the issue, most states and countries feel obligated to investigate all possible ways to reduce the number of stillbirths in their healthcare facilities and communities.

Stillbirth, a tragic outcome that leaves families devastated, is not an inevitability but a condition that, to a considerable extent, is preventable through adherence to medical advice encompassing the preconception phase, pregnancy, and the onset

of labor. The critical junctures of maternal health choices during pregnancy and labor have a critical influence on the morbidity and mortality rates of both mothers and neonates [12].

The escalating prevalence of stillbirths within Nigeria's primary healthcare centres and communities necessitates immediate attention. Analysis of data from the National Demographic Health Survey [11] reveals a concerning trend, wherein the percentage of women delivering in health facilities declined marginally from 66% in 2003 to 62% in 2008, 63% in 2013, and 59% in 2018. Additionally, the Multiple Indicator Cluster Surveys [13] reiterated the gravity of the situation, with 37.5% and 49.0% of women delivering outside health facilities, exposing them to risks of pregnancy complications that may culminate in stillbirths.

Notably, existing literature clarifies the medical causes of stillbirths, but it pays little attention to addressing the connection between cultural myths and prolonged labor that results in stillbirths. Some studies have examined cultural practices linked to pregnancy [14] [15]. But there remains a paucity of research on the impact of cultural myths on prolonged labor and, consequently, stillbirth outcomes. Traditional belief systems continue to influence rural pregnant women's attitudes towards labor and their choice of delivery locations. It also affects birth spacing and the societal value attached to multiple childbirths, particularly in Ebonyi State. Moreover, the myths surrounding the referral of pregnant women facing complications during pregnancy constitute a significant yet inadequately explored aspect of the overarching problem. This study aims to bridge this knowledge gap by systematically investigating the cultural myths associated with pregnancy and their implications on prolonging labor. The study also examines the consequences of these cultural myths on stillbirths among women of reproductive age in Ebonyi State, Nigeria. Additionally, their role in prolonging labor, which in turn contributes to the incidence of stillbirths, is also being investigated. A careful study of these cultural beliefs and their impacts on health-seeking behaviours will provide germane insights for developing targeted interventions. The results of this study aim to not only enrich existing knowledge but also serve as a foundation for designing a community-based approach intervention aimed at mitigating the stillbirth problem in Ebonyi State, Nigeria.

Moreover, the findings of this study will have significant influence on advocacy efforts and policy formulation, offering a paradigm shift within the healthcare system. By spotlighting the cultural factors intricately linked to stillbirths, the study intends to redirect the healthcare focus from predominantly medical and mechanical causes towards a holistic understanding that includes cultural dimensions. It is expected that this recalibration of focus will suggest effective strategies for preventing stillbirths, leading to a significant reduction in their prevalence in Ebonyi State, Nigeria.

2. Literature Review

Stillbirth remains a significant public health concern in many African societies,

including Nigeria. While medical conditions contribute to stillbirths, cultural practices and beliefs play a crucial role in influencing maternal health decisions and outcomes. This review explores the medical causes of stillbirths, the impact of cultural myths on prolonged labor, and the broader consequences on maternal and child health.

2.1. Medical Causes of Stillbirths

Several medical conditions contribute to stillbirths, as highlighted by [16] in their prospective hospital-based study in Soweto, South Africa. Their findings indicate that hypertensive disorders, diabetes, placental infections, fetal membrane and placental inflammations, and pathological placental conditions are key contributors to stillbirths. However, the role of maternal misconceptions, neglect of Antenatal Care (ANC), and delay in seeking medical assistance have received poor attention. Despite the prevalence of these medical factors, cultural influences and societal beliefs continue to shape maternal health-seeking behaviour, which in turn affects pregnancy outcomes.

Studies in Nigeria and the Gambia [17] [18] further emphasized that women who deliver via Caesarean Section (CS) are at a higher risk of experiencing stillbirths compared to those who have Spontaneous Vaginal Deliveries (SVDs). However, timely ANC bookings can help to mitigate these risks. Stillbirths are affected by factors like delay in referring women to secondary health facilities, not having enough medical infrastructure, and socio-economic factors like the mother's education, household income, and media exposure [19]. Additionally, an experimental study by [20] identified severe hypertensive disorders and poor blood pressure monitoring during active labor as major risk factors. When labor is prolonged without proper medical intervention, it increases the likelihood of stillbirths.

Stillbirth continues to be a significant public health issue, with various medical causes—identified across different studies—such as placental abnormalities, maternal health conditions, and infections, which collectively contribute to the tragic outcomes of stillbirths. Understanding these causes is crucial for developing effective prevention strategies. Placental abnormalities such as placental abruption, maternal vascular malperfusion, and chorioangioma are significant contributors to stillbirths [21] [22]. Placental lesions have been found to be the leading cause of stillbirth, accounting for 28% of cases [22]. Maternal health conditions, particularly hypertensive disorders, have also been identified as a major contributor, with a rate as high as 29.7% in some studies [23]. Other medical disorders such as gestational diabetes, severe anaemia, and infections, including HIV and COVID-19, also play critical roles [23]. Infections, particularly ascending infections linked to preterm labor, are another common cause of foetal death [22]. Maternal infections, including syphilis and other viral infections, have similarly been identified as significant [23].

While these medical causes are critical to understanding stillbirth, it is essential

to consider that many stillbirths remain unexplained, highlighting the need for the current study and improved prenatal care to mitigate risks effectively. Moreover, cultural myths and traditional beliefs regarding pregnancy and childbirth further complicate maternal healthcare utilization, often leading to delays in seeking medical help and reliance on traditional remedies, which may inadvertently contribute to prolonged labor and eventually, stillbirths. Integrating scientific knowledge with culturally sensitive interventions remains key to addressing this multifaceted public health challenge.

2.2. Cultural Myths and Misconceptions about Prolonged Labor

Cultural beliefs and myths play a significant role in shaping maternal health practices in Nigeria, particularly during labor and delivery. [24] observed that pregnancy complications are often attributed to supernatural forces, such as witchcraft or divine punishment for perceived transgressions, including infidelity. This belief system discourages women from seeking medical interventions, fostering reliance on traditional remedies or spiritual healers. The implications of such misconceptions are profound, as they not only limit women's access to evidence-based maternal care but also contribute to the misinterpretation of complications like prolonged labor, leading to adverse health outcomes.

One prevalent cultural practice in parts of Ghana and Nigeria is the administration of herbal medications by Traditional Birth Attendants (TBAs) to induce, augment, or control labor and bleeding [25]. While these remedies are widely accepted within local communities, their safety remains scientifically unverified, and their potential contribution to adverse outcomes, including stillbirths, is largely unexplored. The persistence of these traditional practices, alongside deeply ingrained myths, can lead to prolonged labor, increasing the risk of foetal distress and other [26].

The psychological impact of prolonged labor is substantial, as women undergoing this experience frequently report feelings of exhaustion, despair, and frustration [27]. These negative emotions can be exacerbated by cultural myths that misrepresent prolonged labor as a failure on the part of the mother rather than a complex physiological process. Women who experience prolonged labor also report lower perceived safety and personal capacity during childbirth [28], further increasing their sense of vulnerability and distress. Additionally, exaggerated fears surrounding prolonged labor can create unnecessary anxiety, potentially influencing a woman's future birth preferences and increasing reliance on operative deliveries [28].

[29] noted that despite the prevalence of these myths, it is worth noting that prolonged labor does not inherently predict negative outcomes. Instead, associated factors such as delayed medical intervention and operative delivery decisions play more significant roles in determining maternal and neonatal health outcomes. Thus, addressing these cultural misconceptions through education and improved access to skilled maternity care can help mitigate their impact, fostering safer childbirth

experiences for women in Nigeria and similar settings.

2.3. Impact of Cultural Practices on Stillbirths, Prevention, and Policy Implications

The intersection of cultural practices and healthcare access influences stillbirth rates in Ebonyi State. Many women delay seeking professional medical care due to deeply rooted cultural norms that prioritise traditional birthing practices. Delay in labor management, inadequate monitoring and the absence of skilled birth attendants exacerbate the risks of prolonged labor and foetal mortality. Women with foetal death on admission often experience neglect and prolonged suffering, highlighting systemic healthcare challenges. To reduce stillbirth rates, there is a need for increased awareness and education on the importance of ANC. [30] stressed the role of early detection of pregnancy complications through routine medical check-ups. Additionally, integrating traditional birth attendants into formal healthcare system through training and supervision could bridge the gap between cultural practices and modern medical interventions.

3. Methodology

This study employs a comprehensive descriptive cross-sectional approach to critically investigate the influence of cultural myths on pregnant women's health-seeking behaviour and its implications on stillbirth in Ebonyi State, Nigeria. A mixed-methods research design utilizing both quantitative and qualitative data collection methods was used to gain a comprehensive understanding of the subject matter.

3.1. Study Area

The study was conducted in Ebonyi State, situated in the southeastern region of Nigeria (**Figure 1**). The alarming incidence of stillbirths reported in the National Demographic Health Surveys of 2013 and 2018 led to the selection of Ebonyi State. Benue State borders Ebonyi State to the north, Enugu State to the west, Abia and Imo States to the south, and Cross River State to the east. The study is scoped around seven Local Government Areas (LGAs), namely Abakaliki, Ebonyi and Izzi, Ezza North, Ezza South, Ikwo and Afikpo North LGAs.

3.2. Target Population

The study focuses on healthcare workers who are currently employed in healthcare facilities, reproductive health program officers, and other medical personnel. These individuals, who have direct contact with women of reproductive age and provide a valuable source of firsthand information on the impact of cultural myths on labor duration and their association with stillbirths.

3.3. Sampling

A multi-stage sampling technique facilitated LGA selection. First, the study

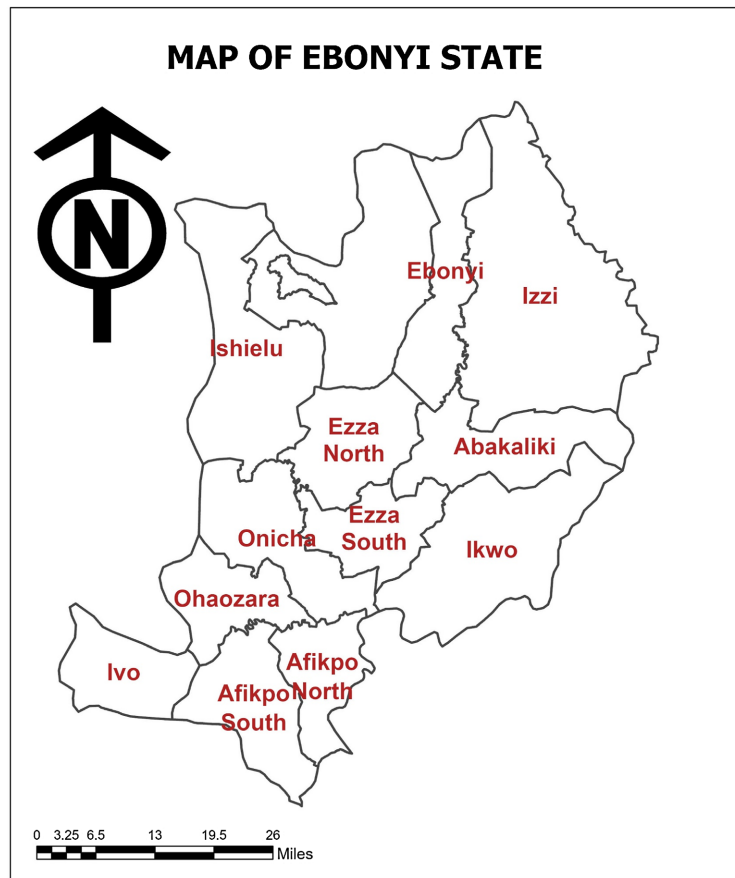


Figure 1. Map of Ebonyi State.

adopted purposive sampling method in selecting the 7 LGAs and 35 facilities across the LGAs. Then a total of 40 healthcare workers were recruited into the study by simple random sampling technique. Additionally, 4 LGA reproductive health programme coordinators were purposefully selected for in-depth interviews. The 7 LGAs from the target population were selected are: Abakaliki, Ebonyi and Izzi (Ebonyi north senatorial zone), Ezza North, Ezza South, Ikwo (Ebonyi central zone) and Afikpo North LGA (Ebonyi South). These LGAs were selected because of the number of stillbirth cases reported into DHIS2 for the period 2021 to 2024. Similarly, only 3 LGAs were selected in Ebonyi north zone, because the region has the high number of cases in DHIS2, secondly Afikpo North was selected because the LGA has the biggest referral health facility in that region, Mater Misericordiae Hospital.

The study conducted 26 key informant interviews, 5 KII among LGA reproductive health officers, 4 Focused Group Discussions (FGDs) sessions. A total of 40 health care workers participated in the study, some participated in both KII and FGD sessions. The study considers saturation of the information to determine the sample size of the study. Since the participants were selected from the three senatorial zones of the state, therefore, the diverse views of health workers from all the zones were elicited.

3.4. Methods of Data Collection

The study sourced quantitative data from the District Health Information System version 2 (DHIS2) platform, a national repository that reports monthly health services data from all healthcare centres in Nigeria. This study extracted data covering total child deliveries and stillbirths (both fresh and macerated) from 698 healthcare centres across Ebonyi State from January 2021 to March 2024 (3 years, 3 months period).

In the data collection stage, the study conducted 26 Key Informant Interviews (KIIs) among healthcare workers, 5 KII among LGA reproductive health officers, and 4 Focused Group Discussions (FGDs) sessions among the healthcare workers in Abakaliki, Ebonyi, Izzi, and Afikpo North LGAs, chosen purposefully due to higher stillbirth cases. In all, a total of 40 healthcare workers participated in the study, some participated in both KII and FGD sessions. The study considers saturation of the information to determine the sample size of the study. Since the participants were selected from the three senatorial zones of the state, therefore, the diverse views of health workers from all the zones were elicited.

3.5. Data Analysis

Quantitative data were analyzed using Excel, employing univariate simple trend analysis to present results in both tabular and chart formats. This analysis spanned 39 months, covering thirteen quarters, allowing for a meticulous examination of the antenatal care first-visit trend in the study area. Qualitative data, transcribed from audio to text, underwent content analysis. The research findings were categorized before formulating the final report. The integration of quantitative and qualitative results ensures a comprehensive exploration of the subject matter, offering a nuanced understanding of the cultural myths' impact on stillbirth rates among pregnant women.

4. Results

4.1. Socio-Demographic Characteristics of Respondents

Table 1 shows the distribution of healthcare workers by LGA. The study deliberately selected seven Local Government Areas (LGAs) to recruit its participants. The Ebonyi north senatorial zone accounted for most of the participants, as shown in the table. They mostly work in health facilities in rural areas. This is because the LGAs in this region have more health centres that have reported the incidence of stillbirths. Another reason is the LGAs have more referral facilities (*i.e.* secondary health institutions). Specifically, the increased occurrence of delayed ANC registration and stillbirths in Ebonyi LGA provides an opportunity for a more detailed analysis of the factors that contribute to these problems.

Table 2 is concerned with the distribution of healthcare workers for the study. It shows that more key informants' interviews were conducted among health care workers. This is because the respondents for this study are easily accessible on an individual basis. It is on this note that 26 KII were conducted across the 7 LGAs,

and the 4 FGDs were conducted in Ebonyi, Abakaliki, Izzi, and Afikpo South LGAs.

Table 3 shows that different cadres of health care workers were selected for this

Table 1. Distribution of healthcare workers by LGA.

LGAs	Senatorial zones	No. of healthcare workers selected
Abakaliki	Ebonyi North	5
Ebonyi	Ebonyi North	10
Izzi	Ebonyi North	5
Afikpo North	Ebonyi South	5
Ezza North	Ebonyi central	5
Ezza South	Ebonyi central	5
Ikwo	Ebonyi central	5
Total		40

Source: Health care workers, LGAs.

Table 2. Distribution of healthcare workers by methods of qualitative data collection.

Instrument (guide)	Number	Target population
Key informant interview	26	Health care workers
Key informant interview	5	Reproductive health officers
Focused group discussion	4	Health care workers

Source: Health care workers, LGA areas.

Table 3. Participants' qualifications and years of experience.

Category of participants	Qualification	Distribution
Health care workers	Community Health Extension Worker (CHEW)	22
	Registered Nurse	5
	Community Health Officer (CHO)	8
	Environmental health officer	5
	Total	40
Years of experience		
Health care workers	5 - 10 years	6
	11 - 15 year	13
	16 - 20 years	9
	21 - 25 years	5
	25 - 30 years	7
	Total	40

Source: Health care workers, LGA areas.

study. However, most of the respondents were CHEWs, while some of them are Community Health Officers (CHOs). It can be inferred that there are more CHEWs in most PHCs compared to other cadres of health care workers. In the aspect of years of experience, the result shows that most of the participants have more than 10 years of experience as health care workers. This means that they are likely to have diverse experience in reproductive and maternal care.

4.2. Most Preferred Place of Delivery by Pregnant Women and Reasons

The study discerns a prevailing trend wherein perceived threats, often rooted in cultural beliefs which most people residing in rural communities of Ebonyi State still adhere to significantly heighten anxieties among pregnant women, compelling them to diversify their sources of antenatal care. Likewise, this study reveals a nuanced landscape wherein the preferred places of delivery predominantly encompass Traditional Birth Attendant (TBA) locations and homes, with health facilities being relegated as the least preferred option. The study discloses that anxiety is common among Izzi, Ezza, Ikwo and Afikpo women, which are the major tribes in the study area. In addition, the study revealed that family network (mothers-in-law and husbands) in most Izzi communities influence the choice of place of child delivery. This influence is further compounded by an array of interconnected factors, including socio-economic status, financial burden associated with delivery costs, etc. For example, primary health clinics in most rural communities of Ikwo charge an average of N8000 for spontaneous virginal delivery. However, due to the low socio-economic status of most of these women, they find it difficult to afford this cost. Another factor that discourages pregnant women from patronizing health clinic is attitudes of healthcare workers, individual choice, prevailing ignorance, reliance on fate, superstitious beliefs, and religious convictions. These factors are prevalent among and applicable to women of reproductive age that are residing in rural communities.

Another finding from the study discloses that lack of transportation is a factor that significantly contributes to the preference of home or TBA deliveries. For example, the distance from communities to health facilities in Ikwo, Ebonyi and Izzi LGAs is more than 5 kilometers. This factor also contributed to discouraging relatives of pregnant women from taking them to health facilities/clinics at the onset of labor.

Delving deeper into the rationale behind opting for TBA deliveries, the study reveals the perception that traditional birth attendants are deemed more qualified than healthcare professionals. The study went further to revealed that in majority of Izzi communities, there is a perception that TBAs have been conducting successful child delivery for several years, and they are closer to pregnant women than health care workers. For example, in Odomoke community of Ebonyi LGA, a popular TBA is said to be giving pregnant women herb during pregnancy, which eases labor. Additionally, there exists an intriguing belief system among pregnant women

that delivering in a hospital is synonymous with frivolously expending their husband's financial resources. For instance, the rural Izzi people, believe that any pregnant woman that gives birth to her child in the hospital is inconsiderate because she wants her spouse to spend more money. Therefore, to avoid this stereotype, pregnant women are encouraged to give birth to their children either at home or at the TBA center. Furthermore, the study demonstrates a disconcerting reality where women delivering in hospitals face the risk of abandonment by their husbands, seen as a strategy to evade the financial obligations associated with medical bills. This corresponds with the response of one of the respondents who shared one of her encounters as a facility officer in-charge:

A woman was booked for CS but when she was in labor at 37 weeks G.A, instead of going to the hospital, she went to TBA because other women were laughing at her. They could not handle the case and brought her to my place. The TBA came with her and wanted to run away, her reason was for people to see that she was strong. (Healthcare worker/Key Informant Interview/Ebonyi LGA)

Other respondents further confirmed how the cost of conducting delivery contributes to high patronage of the services of TBA:

There is a person who gave birth at TBA's place for free and the person who gave birth at the facility paid N15,000. So, because of the cost they prefer going to TBA. (Healthcare worker/Key Informant Interview/Izzi LGA)

Some women won't deliver at the hospital because they want to be seen as Hebrew women, sometimes their husbands abandon them at the hospital because of the medical bill. (Healthcare worker/Key Informant Interview/Abakaliki LGA)

Another respondent opined:

Men see that wives who give birth to their babies at home are strong, that whatever happens, she would give birth to the baby. They are recognized as strong women. For example, a woman gave birth to all her 7 children at home and in the last delivery, the child died. And she said the child was stubborn which was why the baby died. But once they (men) are called to take their wives to the hospital, they see it as if their wives are weak and cannot give birth to the baby on their own. (Health care worker/FGD/Ebonyi LGA)

4.3. Cultural Misconceptions about Prolonged Labor

Considering the contrasting decisions made by pregnant women in response to medical advice, the study's results reveal a connection between prolonged labor and longstanding cultural misconceptions. The findings from the study show that for instance, in some Izzi communities, there is a prevailing belief system that prolonged labor is an aberration, attributing its occurrence to spiritual causes. Central to this perspective in some Ikwo, Ebonyi and Izzi communities is the conviction that only women have affiliations to spiritual entities, such as the *Ogbanje*, which creates impediments that prevent the natural and home-based delivery of their infants. The study further reveals that such expectant mothers are urged to confess their sins to remove these impediments and avert the necessity of a cae-

sarean section. In these instances, cultural norms prescribe a ritualistic approach to address the perceived sins. For instance, in Ogbala community of Ebonyi LGA, there is a belief that once a pregnant woman's labor is prolonged, it is concluded that the woman is *Ogbanje*, meaning that she is possessed or the gods of the land are not happy with her. These findings underscore how deeply-rooted cultural beliefs contribute to delay in seeking medical intervention, with the conviction that spiritual appeasement can mitigate the need for surgical delivery. Moreso, the study highlights the inclination of rural families towards seeking the counsel of native healers when confronted with a pregnant woman experiencing prolonged labor. This reflects a broader trend of consulting traditional practitioners to discern the underlying reasons for the delay in achieving a spontaneous vaginal delivery at home.

4.4. Religious Doctrines Prohibit Members from Attending Healthcare Centres

The study also expounds the interplay of religious beliefs and healthcare choices, shedding light on a compelling aspect of maternal care. The research findings emphasises the profound impact of religious doctrines on the birthing choices of some women. Certain churches impose religious embargoes, leading a significant number of women to opt for prayer houses or Traditional Birth Attendant (TBA) centers. Notably, the study identifies "Faith Tabernacle" as a prominent entity in Ebonyi State. It was observed that they have members in some of the communities in Ebonyi evidencing their role in discouraging members from seeking medical interventions such as medication or blood transfusions during childbirth. The study suggests that church members who adhere to such restrictive doctrines may be more vulnerable to experiencing complications during childbirth.

One of the respondents shared her experience of how religious beliefs contributed to the death of a pregnant woman in Ndigenle community:

There is a piteous case I experienced sometime in last year. The woman was in labor for the whole day but they did not bring her to the healthcare centre because the mother-in-law wanted to take the delivery. When the labor was not progressing, the mother-in-law brought the pregnant woman to my healthcare centre. When I examined the pregnant woman's condition, I observed that the pregnancy is not progressing. I immediately referred her to Alex Ekwueme Federal Teaching Hospital, Abakaliki (a secondary healthcare center). But her husband became angry over it, asking why they went to the hospital and saying that they do not have Faith in God. He took them back home. I was told that the pregnant woman and her baby died later that night. It was a painful experience and I believe that death could have been prevented but for their religious doctrine. (Healthcare Worker/FGD/Izzi LGA)

4.5. Pregnancy and Female Genital Mutilation (FGM)

Female genital mutilation is prevalent in some of the rural communities in Izzi,

Ebonyi and Ikwo LGAs. The research findings revealed that in some of the communities, it is a traditional practice to view a pregnant woman without circumcision as an immature girl because it is perceived as the transition from the stage of being a girl to being a woman. The mutilation of a girl's clitoral region accomplishes this. Consequently, they are now capable of procreation and can enter a marital relationship. In Ugbodo and some communities in Ebonyi LGA, some women undergo circumcision during pregnancy because they believe an uncircumcised clitoris might hinder the delivery of a baby. People believe that a woman who has not undergone Female Genital Mutilation (FGM) will not receive a ceremonial burial upon her death, regardless of the number of children she has. However, this practice is no longer prevalent in Abakaliki, the state capital. Furthermore, the findings indicate that female genital mutilation is viewed to facilitate conception for married women. According to one of the responses, if a married woman is unable to conceive, it is customary for her husband to return her to her parents so that they can circumcise her.

Few of the key informants alluded to the fact that the circumcision procedure they practice involves full excision of all genitalia in the region, including the clitoris. Certain women may have scars that impede their ability to exert force during childbirth. Even when the baby is expected to be delivered smoothly, the tightness caused by these scars might cause the unborn child to struggle, perhaps leading to stillbirth. When the infant experiences prolonged difficulty in exiting the uterus and labor fails to advance, the infant gets deprived of oxygen (asphyxia) and experiences extreme fatigue. If not handled by professionals or referred to a secondary institution for a caesarean section, it may result in stillbirth. Infibulated women, whose genitals have been securely closed, have a perineal incision (episiotomy) to facilitate safe delivery of the baby. One of the respondents asserted that throughout labor, vaginal examination is performed on the woman. During such examinations, if she has undergone FGM, it can be observed that the space in cervix area is constricted, causing the woman to experience prolonged labor. However, the situation differs consistently for a woman who has not undergone FGM, where the vaginal region will readily open during childbirth, without prolonging labor.

As to the statement of a respondent, who holds the position of a reproductive health coordinator, the following was stated:

Another thing that contributes to prolonged labor is female genital mutilation. This is because, by the time the baby in the womb has tried to come out, there will be no way [because of cervix constriction], the baby becomes exhausted, or the woman starts pushing when she is not supposed to push. This is more dangerous if the most experienced healthcare worker is not on ground and the other person managing the case may not be doing it correctly. By the time the woman and the baby get exhausted, somehow they will come out asphyxiated and before you know it, they are gone. (Reproductive health coordinator/KII/Ebonyi LGA)

4.6. Problems with Delay During Labor

This study also shows that most cultural beliefs affect pregnant women's attitudes. There exists a cultural practice of family members delaying transporting pregnant women to the hospital when labor begins. Their first-line of action is to try to conduct the delivery at home or take them to a TBA. Some Izzi people believe that when a pregnant woman's labor is not progressing, it is because it is not the time that God destined for her to give birth to her child. This perception discourages them from acting proactively when the labor is not progressing. The study further illustrates instances where protracted labor causes prenatal or maternal death in Ebonyi LGA. Most respondents in the study area believe that delay in getting pregnant women to healthcare centres during labor is the cause of most stillbirths and maternal mortality. Family members of pregnant women that reside in rural areas often initially transport women to TBAs, chemists, or conduct home deliveries. Women in prolonged labor have no option other than healthcare centres. Below are a few cases that depict the consequences of prolonged labor on women and the child:

A woman once came in with "Shoulder Dystocia", the head of the baby was out but the shoulder could not pass. The baby stayed that way for 24 hours till we got a technique to use and deliver the baby. Retain 2nd twin, the 1st twin was out but the 2nd one was not out and stayed for 24 hours. They were referred because it was late (around 2:00am) and there was no doctor [on duty]. (Patron/KII/Ebonyi LGA)

In another development, one of the key informants said:

During prolonged labor, that is when they remember hospital, while some will call a chemist for assistance. However, some of them will still insist and stay at home believing that it is not yet time for the baby to come out, that when it is time, God will deliver the baby. (FGD/Abakaliki LGA)

We have ever had a case like that, the woman died due to delay in bringing her to the hospital. Before the woman was brought to our hospital, they have taken her to different untrained medical workers' places, who eventually compounded the complications before she was brought here. On arrival at our hospital, she was diagnosed of hemophilia, this is a disorder where blood does not easily clot. The husband does not know about this condition. When she was brought to our facility, it was already late because she had lost a reasonable amount of blood. She eventually died but the baby survived. (Healthcare Worker/KII/Izzi LGA).

4.7. Referral of Prolonged Labor: Within A General Perception of Community

This study discovered that a common misconception rural woman with low socio-economic status have about referring pregnant women in prolonged labor to secondary healthcare centres is that they will ultimately die. Unlike those women in the urban areas, pregnant women in the rural Izzi, Ezza and Ikwo communities believe that when referred to secondary healthcare centres, the chances of survival

are minimal. In another vein, most respondents said that the low economic status of women in most LGAs of Ebonyi State contribute to their inability to afford transport fare to the nearest secondary healthcare centre, let alone pay their medical bills. This is why they ignore referrals and choose other close-by places to give birth to their babies, regardless of the delivery outcome.

Another negative perception most pregnant women in rural communities of Ebonyi State have about referral to secondary healthcare centres is how most secondary healthcare personnel handle referral cases. Healthcare professionals in most secondary healthcare facilities lack empathy and regard for referred patients, delay in care, and hospital bureaucracy. The argument was that these and other factors deterred referred pregnant women in prolonged labor from honouring referrals to higher healthcare facilities. This pushes some of these pregnant women to seek medical treatments from quacks. According to one of the respondents, who presented her recent experience with a referral center in the state capital.

One of my patients that had prolonged labor because the baby breeched in a posterior position in the womb. I filled a referral form and referred her to the state teaching hospital, but, the woman told me outrightly that she will not go to that hospital. That her previous encounter with healthcare workers in the facility was painful. When she was brought, she was not attended to for close to an hour. The healthcare workers on duty did not attend to her immediately. Her husband had to start shouting and creating a scene in the labor and delivery unit before one doctor came and instructed the nurses to rush her into the labor room. Because of this experience, this woman said she will never go to that hospital again. (Officer In-charge/KII/Ezza North LGA)

The result of the study further shows that there prevails a perception that the quality of the healthcare services in referral centers is usually poor. Some of the respondents further affirmed the above claim regarding attitude of health worker.

4.8. Caesarean Section (CS): The Silent Stigma among Community Women

It was deduced that in several communities in Ebonyi State, Spontaneous Virginal Delivery (SVD) is perceived as the sole acceptable mode of childbirth. The researchers also observed that in most rural Izzi, Ezza, Ikwo and Ohaozara communities, the most preferred and culturally accepted means of childbirth is SVD. The people of these communities have different misconceptions about pregnant women giving birth through cesarean section. In some parts of Ebonyi and Izzi LGAs, it is believed that pregnant women that give birth to their children through CS are weak and lazy women who do not have the strength to push the baby during labor. More so, in some parts of Ugbodo, women who give birth through CS are seen as cursed or possessed by mystical forces that prevented them from delivering their babies through SVD. These misconceptions about women who give birth through CS contribute so much to stigmatization, husbands divorcing them, husbands marrying more spouses, etc. These are some reasons why women in prolonged

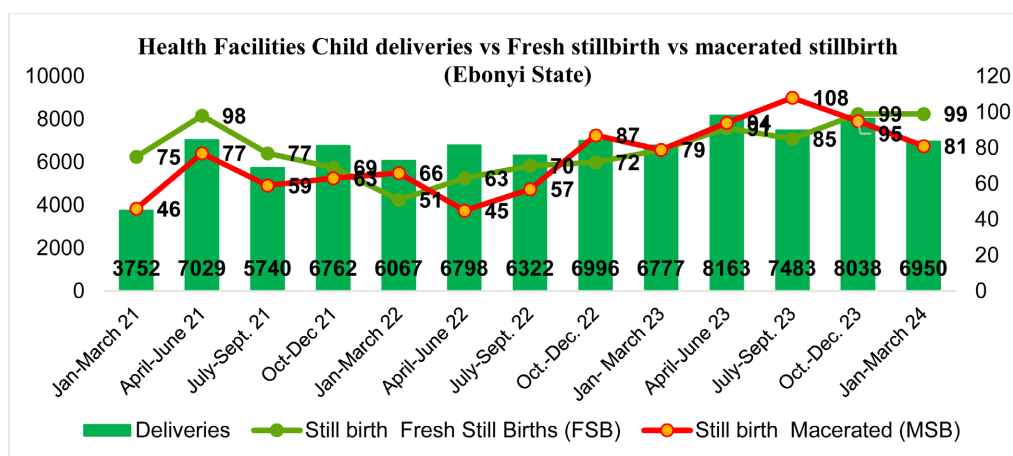
labor may prefer going elsewhere instead of opting for CS. Such health-seeking behaviour is known to contribute significantly to stillbirths and maternal mortality among the study population. One person recounted her neighbourhood experience as follows:

A neighbour of mine gave birth to two of her children through CS and was told that the last one would be the same way. She wanted to show her fellow women that she could push a baby. But she finally gave birth through CS and few days later she came out of her compound sweeping the front of her house. This is to deceive other women that she gave birth through SVD and that she is strong. (Health care worker/KII/Izzi LGA)

The study went further to extract health services data from the Nigeria District Health Information System (DHIS) platform. Data on Ebonyi State for the period of January 2021 to March 2024 was downloaded. Below is the table and chart from District Health Information System version 2 (DHIS2), depicting the rates of stillbirths in the state. DHIS2 is a nationally recognized platform for reporting health service data on monthly basis.

4.9. Stillbirth Rate

Figure 2 displays the statistics about the overall number of deliveries compared to the total number of stillbirths from January 2021 to March 2024. The graph illustrates a positive correlation between the number of child deliveries in health facilities and the incidence of stillbirths. This count excludes deliveries that occurred within the neighbourhoods (home, religious home, TBAs, etc.). The state's average stillbirth rate is 153 stillbirths per month. The total number of fresh stillbirths is higher than that of macerated stillbirths. Some of these deaths can only be prevented if pregnant women follow professional medical advice. Additionally, it is crucial to stop harmful cultural practices and correct cultural misconceptions that can negatively impact pregnancy outcomes.



Source: DHIS2.

Figure 2. Health facilities report on child deliveries vs stillbirths in Ebonyi State for the period quarter one 2021 to quarter one 2024.

5. Discussion of Findings

This study critically reviewed the account of healthcare workers on cultural myths associated with prolonged labor and consequences on stillbirth. The study revealed that most pregnant women favoured delivering their babies in traditional birth attendant settings and at home. This corresponds with findings of [31] in Ethiopia where a large portion of pregnant women preferred home deliveries. This preference for home delivery was connected to household and community supporting elements, such as not discussing the delivery location with a partner, not attending women's development army meetings, and feeling that the community does not support them.

In addition, this study shows that most women do not to deliver their babies in healthcare facilities because family networks, particularly their mothers-in-law and husbands, influence most their decisions about where to deliver their babies. There is also a misperception among rural women that TBAs are more qualified and experienced than modern healthcare workers. Other factors that determine a place for child delivery include socio-economic status, financial burden, healthcare workers' attitudes, superstitious beliefs, and so on. This aligns with [32], who postulated that the reason for the choice of home delivery among pregnant women residing in rural areas could be associated with a lack of adequate healthcare facilities and personnel; even where they exist, they are long distances away from the reach of most rural dwellers.

There is a connection between long-held cultural misconceptions and prolonged labor. Most rural, remote communities perceive and interpret the prevailing belief system often from a spiritual perspective. This cultural perspective holds that only women belong to spiritual entities, such as the *Ogbanje*. *Obanje* is referred to the spirit or spiritual forces that are impeding the natural progression of labor and the safe delivery of a baby. Rural areas consult the local gods (deities) to determine the cause of prolonged labor and typically encourage the affected woman to confess her sins to avoid the need for a caesarean section. This consultations with native healers further prolong labor, leading some of these women to experience stillbirth. This aligns with the findings of [33] study in Uganda and Kenya, where women typically viewed stillbirth as a sign of unsuccessful luck or infidelity. When a woman experiences a stillbirth, community members often stigmatize family members. However, this diverts from the findings of studies conducted in Ghana, which revealed that it is a common religious practice for relatives of a woman in prolonged labor to go into prayer to God [14]. The studies conducted by [34], and [25] support this finding.

Furthermore, according to another study [35], the common cultural belief that the Igbos have about *Obanje* is that *Obanje* results from the insurrection of human destiny by the wilful alliance of newborns with the gods of the land, who protect the interface between birth and pre-birth (spirit) existence.

Furthermore, this illustrates the widespread stigma that most rural community members hold against women who birth their babies through caesarean sections.

Rural community members believe that “spontaneous virginal delivery” is the sole acceptable mode of childbirth. People perceive pregnant women who give birth through Caesarean Section (CS) as weak, lacking the strength to push and deliver their babies through a virginal birth. People also hold the belief that mystical forces curse or possess these women, preventing them from delivering their babies naturally. The misconception about women who gave birth through CS contributes to stigmatisation, husbands divorcing them, husbands marrying more spouses, etc. These are some reasons why women in prolonged labor may prefer going elsewhere instead of opting for CS. This health-seeking behaviour contributes to stillbirths and maternal mortality. However, the prevalence of caesarean section among women from different South and South-East Asian countries shows that socio-economic status of urban pregnant women influences preference of Caesarean section to SVD compared to pregnant women in rural communities [36].

This study further illustrates that some women’s delivery choices are influenced by religious doctrines. Notably, the dominant “Faith Tarbernacle” church in the study area is well-known for its opposition to modern medication and blood transfusion. This doctrine is the reason most women prefer to deliver their babies in prayer houses, homes, and TBA centers. Because church members adhere to this restrictive doctrine, they are more likely to experience complications during childbirth.

The prevalence of Female Genital Mutilation (FGM) is high in most rural communities within the study area. When a girl undergoes FGM, it signifies her transformation into a complete woman. Female genital mutilation involves the scraping and mutilation of the woman’s clitoral region. In certain situations, the belief that an uncircumcised clitoris might hinder the delivery of a baby necessitates circumcising an uncircumcised pregnant woman before she gives birth. This differs from the position of [37], who believe that FGM causes delay during labor and can lead to death. Another socio-cultural stigma is the lack of a ceremonial burial for such a woman after her death. This practice of mutilating the clitoral leaves a permanent scar in the area that might cause delay in labor progression, which, if not referred to qualified healthcare professionals, can result in stillbirth.

The study further reviews the major cultural misconceptions associated with referral of pregnant women in prolonged labor and its consequences on stillbirth. Rural women often believe that referring a pregnant woman in prolonged labor to a secondary health facility automatically results in her death. Other factors that prevent pregnant women from honoring referrals to higher healthcare centres include the attitude of healthcare workers, hospital bureaucratic bottlenecks, and so on.

6. Conclusions

Delays in accessing medical care due to cultural beliefs and customs around pregnancy and childbirth contribute to stillbirths. There has been an increase in the

number of stillbirths per month. There is an average of 15 stillbirths every quarter. 698 health facilities in the study area recorded a total of 2121 stillbirths over a 39-month period from January 2021 to March 2024. This large quantity necessitates immediate action. The major type of stillbirth reported is fresh stillbirth. This study investigates attitudes that contribute to stillbirth. Cultural myths have an impact on pregnant women's health-seeking behaviour.

The place where a woman gives birth can influence the pregnancy outcome. Expectant mothers prefer to deliver their babies at a TBA location and at home rather than in a hospital. They choose TBA/home deliveries because of the expenses associated with services rendered at the healthcare clinic and transportation too. Moreover, the majority accept only spontaneous virginal births. The majority classify caesarean section deliveries as atypical. Such women are considered lethargic and cursed by the gods. It thus creates a negative social stigma for women who undergo CS.

Healthcare personnel are believed to be deficient in the "expertise" and "credentials" possessed by conventional birth attendants. People claim that they possess extraordinary attributes that enable them to perform difficult tasks. People deceive women into believing that prolonged labor is not natural. Often, accusations of adultery or the beliefs in *Ogbanje*, a term describing a child who repeatedly dies and reincarnates, are associated with women who experience prolonged labor. To give birth to her child, she must openly acknowledge her wrongdoing to the community's deities. Religious limitations are another factor contributing to the preference for TBA/home delivery. In the study area, the Faith Tabernacle Church prohibits its members from undergoing blood transfusions or hospitalisation.

Some people in rural communities continue to engage in the practice of female genital mutilation. Clitoral mutilation is considered a traditional practice marking the transition from girlhood to womanhood. The intact female genitalia tend to dilate more readily during childbirth, while women with mutilated clitoris can experience prolonged labor, in which case foetal asphyxiation, a lack of oxygen in the newborn, causes stillbirth. Although, if a skilled birth attendant promptly refers such a case to a higher-level clinic, the woman in labor can have a safe child delivery.

Disregarding referrals to secondary-level health facilities contributes to the occurrence of stillbirths. The misconception is that every woman who is referred to secondary health facilities has a slim chance of survival. People often perceive referral destinations as places of death. Another assumption is that a woman in prolonged labor, upon referral to a secondary health facility, must undergo a caesarean section.

7. Recommendations

The government should build more primary healthcare clinics in rural communities and develop a sensitization program to increase awareness about the ad-

vantages of using modern healthcare clinics, as well as some practical methods to decrease the practice of patronising traditional birth attendant places and delivering babies at home. This action will enable Nigeria to achieve Sustainable Development Goal (SDG) Number 3: *positive health and wellbeing*. One way to disassociate people from their belief in *Obanje* is for the State Ministry of Health to design a sensitization program that aims to educate the people about the consequences of this belief on maternal and neonatal health. For example, they should select “community health champions” who should be provided with funds and logistics to transport women in prolonged labor to secondary healthcare centers. When these pregnant women have successfully given birth in the hospital, they should be used to create awareness in the community. This is likely to bring a change of perception among those that associate prolonged labor with *Obanje*.

Considering how influential TBAs are in the community, State Ministry of Health should train and sensitize them on the duration of time a pregnant woman should stay with them before they can refer them to secondary healthcare centre. TBAs also need to assist Ministry of Health in discouraging home deliveries.

State Government, through the Ministry of Health and in partnership with the National Orientation Agency, should develop an indigenous sensitisation campaign to raise awareness about the importance of performing a caesarean section on a woman experiencing prolonged labor. Documentaries showcasing women from rural communities who underwent CS and are still alive are also necessary.

There is a need for government and partners to collaborate with traditional and religious leaders to discourage the attitude of stigmatizing women who give birth through CS. It may take a long time, but with consistent focus, there will be behavioural change in the way people perceive delivery by CS.

This paper further recommends that the government should enforce the ban on the practice of female genital mutilation. Monitoring committees should be set up in rural communities that will be responsible for arresting those who default on the law. In addition, the government should provide functional ambulances in primary healthcare centres to transport women in prolonged labor when referred to secondary healthcare centers. This will eliminate the financial burden of transportation to the secondary hospital upon referral.

Lastly, considering how sensitive cultural beliefs are and rebellion that will come along with an attempt to change these cultural myths. This study encourages the use of dialogue, continuous community sensitization and the use of community-gate keepers. When this strategy is adopted, after a while, there will be behavioural change and improved knowledge on management of prolonged labor and honouring referral. This will contribute to significantly reducing the rate of maternal death and stillbirth in Ebonyi State, Nigeria.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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