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Religion and Pregnancy: Post-Partum Mothers Religious Beliefs and Practices in an Urban Area in Southwestern Nigeria

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ABSTRACT
Religiosity and health are inter-related especially within the African context where illnesses have been linked to spiritual effects many years ago.Pregnancy is a physiological phenomenon and an enjoyable period of a woman's life and childbirth is an important phaseof her life.The aim of this study is to determine thereligious beliefs and practices in pregnancy and labor among post-partum mothers in selected primary health centers in Ado-Ekiti, Ekiti State. Two health facilities were purposely selected. A descriptive cross-sectional design with the use of an adapted well-structured questionnaire was employed. One hundred and eighty-two (182) post-partum women who were selected using convenience sampling method participated in the study. Data were analyzed and presented using descriptive (frequency, percentages and means) and Chi-square was used for observed differences and relationships between study variables. Result showed that 56% of the participants were within the age range of 24-28 years and 73.1% were Christians. Majority (78.6%) of women strongly agreed that God is the ultimate midwife. Also, 42.9%agreed that their prayers carry meaning and personal emotion while 52.7% believe God can deliver them safely without ante-natal care, 33.5% also believe that anointing oil or other drinks from religious leaders are more effective than hospital prescribed drugs while 21.4% were of the option that labour process (childbirth) is easier in maternity homes belonging to their faith. One-third (34.1%) of the participants indicated that they will not obey antenatal care directives if their religion says otherwise. Healthcare professionals especially midwives need tointensify their health teachings to pregnant women as well as the community at large on the importance of seeking ante-natal and post-natal care. So as to encourage their adherence to appropriate health practices thereby improving the health of mothers and babies.

Keywords: Religious beliefs, religious practices, pregnancy, labor

INTRODUCTION
In nursing and midwifery discourse, spirituality is fundamental constituent of care and should not be downgraded to the background(Crowther & Hall, 2015). It forms an important part of the total care provided to clients and their families in all spheres of nursing and midwifery (Tiew, Creedy & Chan, 2013). Religiosity and health are inter-related especially within the African context where illnesses have been linked to spiritual effects many years ago (Naser, *et al.* 2012). Witchcraft is linked with illness within the African context including problems of childbirth (Aziato, Odai, & Omenyo, 2016). Also, pregnancy and childbirth are related to religious and traditional beliefs and practices in many countries (Elter, *et al.* 2016)

Pregnancy is a physiological phenomenon and an enjoyable period of a woman's life and childbirth is also perceived an important phase life (Cunningham, *et al.* 2010). Each pregnant woman acts in a unique way regarding tolerating pregnancy and labor pain which involves three stages of labour: the shortening and opening of the cervix, descent and birth of the baby, and the delivery of the placenta in comparison to other pregnant women (Memon & Handa, 2013). Many factors affect the process of pregnancy and childbirth such as the woman's knowledge, economic status, unwanted pregnancy, abortion records, and undesirable physiological symptoms like vaginal bleeding and fever with anxiety related to the pregnancy (Ding, *et al.*, 2015)

Women all over the world are confronted with many difficult choices during pregnancy and child birth. Cultural practices, beliefs, and taboos are often implicated in determining the care received by mothers during pregnancy and child birth which is an important determinant of maternal mortality (Ha *et al*. 2014). Globally, on a daily basis, at least 800 women die from complications related to

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pregnancy and childbirth (World Health Organization, 2014). These deaths are mostly due to obstetric complications that could have been easily prevented ifmothershave received the appropriate care they deserve during their pregnancy, delivery, and postnatal period (World Health Organization, 2014).

Nigeria, the most populous African country, is a religiously pluralized society with Christians found predominantly in the south, while the Muslims occupy most of the northern part of the country (Sampson 2014; Yesufu, 2016). Religion is part of everyday conversation within the country. Historically, women were cared for by traditional birth attendants (TBAs) who mainly rely on the use of herbal medicine (Izugbara, *et al.* 2005; Ohaja & Murphy-Lawless, 2017; Aziato & Cephas, 2018). Traditional healthcare practitioners are often referred to as native doctors/healers, and they were the only available healthcare providers in the pre-colonial period (Izugbara, *et al.*2005). Ancient priest-physicians were known for their ability to provide physical healing as well as spiritual care (Rhys, 2014). Thus, traditional medicines are believed to have both therapeutic effects and spiritual healing powers. The latter is often considered lacking in the modern medicalized environment (Asamoah-Gyadu, 2014).

Ohaja, Murphy-Lawless and Margaret (2019) in their study showed that an anthropological exploration of native societies portrays pregnancy and childbirth as both a sociocultural and spiritual circumstance. Thus, the popularity of traditional healthcare providers among women during the pregnancy and childbirth is not a surprise, despite the availability of modern healthcare systems (Izugbara, Etukudoh & Brown, 2005). Healthcare practices, including the ways of being during pregnancy and birth, changed during the colonial era. Christian missionaries who came with the colonial masters, though not all, condemned the use of herbal medicine, described it as evil, and also condemned what they labelled as pagan practices (Asamoah-Gyadu, 2014; Williams, 2018).

Indigenous or traditional midwifery was also viewed in disparaging terms. Central to the modernization and evangelization project of Christian missionaries was the relocation of childbirth from the home to the hospital setting (Williams, 2018). In the institutional background the medicalization of pregnancy and childbirth thrived; and opened the way for more stress on the expected objective physical or physiological facet of the pregnancy and birth activity, diminishing the women's personal experiences, including their religious and spiritual care necessities (Williams, 2018).

Previous researchers have reported several traditional beliefs and practices associated with pregnancy, labour and the post-partum period. Some of these traditional beliefs and practices include food and water restrictions (Elter, *et al.* 2016; Oni & Tukur, 2016; Heidari, *et al.* 2015); avoiding specific places such as the graveyard (Choudhury & Ahmed, 2011); not going out at specific times in the day(Ha, *et al.* 2014), not associating with some people deemed to be evil, and drinking special herbal preparations (Heidari, *et al.b* 2015). Some women are restricted from working during pregnancy while others are not (Naser, *et al.*2012). During labour, women suffer negative traditional beliefs that demand that they confess unfaithfulness to their partners when labour is delayed especially for those who deliver at home (Okafor, 2010). But specific dietary restrictions such as avoidance of fish in diet may predispose the pregnant woman to dietary deficiencies (Tasci-Duran & Sevil, 2013; Oni & Tukur, 2016). Allahdadian and Alireza(2015) revealed that harmful traditional (religious) practices that affect children and women are female genital mutilation, milk teeth extraction, food taboo, uvula cutting, forbidding food and fluids during diarrhea, keeping babies from exposure to sun, and feeding newborn babies with fresh butter.The aim of this study was to investigate the religious beliefs and practices in pregnancy and labour among post-partum mothers in selected primary health centers in Ado-Ekiti. With wealth of existing literatures revealing the unavoidable roles of religion among women especially in pregnancy and labour to delivery (childbirth) that pregnant women's religious believes can have effect on their pregnancy and childbirth. Thus, it is envisaged that findings from the studywill significantly influence a positive decision making that is void of the influence of religion without undue disregard or disrespecting the religion of the women.

THEORETICAL FRAMWORK

The theoretical framework for the study was the Health Belief Model (Carpenter & Christopher, 2010). The Health Belief Model (HBM) which was first developed in the 1950s by social psychologists Hochaum, Rosenstock and Kegels working in the U.S. Public Health Services (Carpenter & Christopher, 2010). It is a psychological model that attempts to explain and

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predict health behaviors and this is done by focusing on the attitudes and beliefs of individuals. Health Belief Model has concepts that are essential to the theory, the concepts include; Perceived severity, Perceived susceptibility, Perceived benefits, Perceived barriers, Cue to action and Self-efficacy. For the purpose of this research, the 6 constructs of this model were applied. The application of the model in this study is as follows:

Perceived susceptibility: this refers to beliefs about the likelihood of getting a disease or condition. For example, pregnant women must believe the likelihood of being negatively affected by some religious practices such as food restrictions before taking up antenatal to clear one's doubts. The health belief model predicts that women will be more likely to take up antenatal when they feel or perceive that their religious practices would bring about any form of pregnancy related incidents like maternal mortality, infant mortality and others.

Perceived severity: this refers to the severity of a health problem as assessed by the individual. This concept refers to the perceived seriousness of an illness or complications if left untreated resulting in consequences such aspain, disability or even death. For example, if a pregnant woman think that some religious practices and beliefs would have serious medical, social and economic consequences, she is more likely to refrain from them. Having personal knowledge regarding the importance of the health of the unborn child and the mother herself has been evidenced to allow actions to be taken to prevent the adverse outcome of pregnancy related incidences.

Perceived benefit: this refers to how efficient/effective the individual feels the medical intervention (be it preventive or curative) is. For example, total adherence to antenatal lessons. How beneficial an individual feels the interventions are, determines their attitude towards it, their will to follow through with it as well as adopting it as a lifestyle. Even if a person perceives personal susceptibility to a serious health condition (perceived treat), whether this perception leads to behavior change will be influenced by the person's belief regarding the perceived benefits of the various available actions for reducing the disease threat. For example, women must believe that a course of preventive behaviors available would be beneficial in reducing the risk of maternal mortality and infant mortality.

Cues to action: this are the prompts that are needed to move the person into the state where he/she is ready to take the prescribed action. They are the factors that trigger the individual to engage in the perceived benefits. Readiness to action (Perceived susceptibility and perceived benefits) could only be potentiated by other factors particularly by cues to instigate action. For example, pregnant women would be more likely to engage in preventive behaviours such as refraining from unwholesome religious beliefs and practices in pregnancy if they are reminded by the health care providers.

Perceived self-efficacy: this is defined as the conviction that one can successfully execute the behavior required to produce the outcomes. For a successful behavioral change, people must feel threatened by their current behavioral pattern (perceived susceptibility and severity) and believe that change of a specific kind will result in a valued outcome at an acceptable cost (perceived benefit). Likewise, they must see themselves as competent (self–efficacious) to overcome perceived barriers to appropriate actions. For example, pregnant women should be confident that they could uptake antenatal classes consistently, followed all teachings and refrain from unhealthy religious beliefs and practices.

Perceived barriers: this is a person's perceptions of the difficulties he/she would encounter in taking the proposed actions, including both physical and psychological barriers. Previously published barriers affecting the uptake of antenatal programmes or strict adherence to unhealthy religious practices include differences in social class, educational levels, knowledgeand awareness, poverty, availability of facilities and equipment as well as the availability of skilled or trained health personnel (Adeniyi & Erhabor, 2015)

Generally, the desired health behavior (i.e. healthy pregnancy and labour related beliefs and practices) is influenced by many interrelated concepts, such as, perceived susceptibility, perceived severity, perceived benefits, cues to action, perceived self-efficacy and perceived barriers. These interrelated concepts will determine an individual's willingness to adopt a healthy lifestyle, adhere to health beliefs without religious bias and have access to appropriate health information.

METHODOLOGY

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STUDY SETTING

The study was carried out in twoselected Primary Health Centre, located in Ado-Ekiti, Ekiti State, southwest Nigeria. The Health Centres are public health institutions with the sole aim of reducing both maternal and child mortality and morbidity at grass root level. They consist of various units: antenatal clinic, labor ward, post-natal clinic, pharmacy and laboratories. The personnel employed at the Health Centres were nurses, midwives, community health extension workers, and health assistants. The services offered at the Health Centres were antenatal and postnatal clinics, delivery, circumcision, family planning, treatment of childhood diseases (for under five children) and immunization.

STUDY DESIGN AND TARGET POPULATION

A descriptive cross-sectional design was employed using quantitative approach to assess the religious beliefs and practices in pregnancy and labour among post-partum mothers two selected health centers in Ado-Ekiti, Ekiti State Southwest Nigeria.

The study was conducted among women attending postnatal clinics in the two selected health care facilities in the study area. According to the ward record of January 2020, a total population of 316 postpartum mothers in both Comprehensive Health Centers and Basic Health Centre combined. The sample size for this study was calculated as described by Taro (1967). Adjustment for a 10% rate of non-responses and invalid responses yielded a final sample size of 182. For the choice of health facility, a stratified random sampling was utilized to choose the two health facilities in Ekiti State. The stratifying attribute for this study was the average number of clients seen per month in the health centres. The stratified random sampling technique is divided into three steps:

Step 1: Stratifying the sample frame into their constituent stratum.

Step 2: Decide on sample size and proportion of stratum.

Step 3: Draw simple random sample of required size from each stratum.

At the second and last stage, the convenience sampling method is chosen due to the small population size and the ease of contact of the prospective respondents with the researcher. The inclusion criteria for this study were; women attending postnatal clinics at the health centers who were willing to participate in the study.

INSTRUMENT FOR DATA COLLECTION

The research instrument was a structured adapted questionnaire based on information from Uzeyir, (2016) as well as from relevant literature search, necessary adjustments were then made to meet the objectives of the study.

The questionnaire was arranged in four sections; Section A contains the demographic data of the participants; Section B contains questions designed to identify religious beliefs in pregnancy and labour, factors influencing beliefs in pregnancy and labourusing a combination of multiple choice and closed ended questions. Section C was designed to assessreligious practices in pregnancy while Section D was designed to identify faith-related barriers to utilizing maternal health care serviceswith closed ended questions and each section correlates with the research objectives. The questionnaire was administered to 182 post-partum women.

VALIDITY AND RELIABILITY OF INSTRUMENTS

The validity was based on face and content validity. To establish reliability, the test-retest method was used. The questionnaire was pre-tested on ten participants who had indistinguishable characteristics with the study participants. Three weeks later, the questionnaire was re-administered to same set of participants who participated in the pre-test, to measure the stability of scores across time. The reliability coefficient was calculated to test for the internal consistencies of response and to determine if the instrument is reliable for the study. The Kappa's coefficients generated were 0.752, 0.873 and 0.845 for the section B, C and D of the questionnaire, which were indications of good agreements.

STATISTICAL ANALYSIS

Statistical analysis of data was done using SPSS (version 23) software for windows. Descriptive statistics were calculated as frequencies, percentages and means. Between groups, percentages were compared with Chi- square for observed differences and relationships between study variables. Level of significance was considered at p-value less than 0.05.

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ETHICAL CONSIDERATION

Ethical approval to conduct the study was obtainedfrom the Research and Ethics Committee of Afe Babalola University, Ado-Ekiti. Also, ethical approval to conduct the study was obtained from the Clinic Managers of the two selected Comprehensive Health Centre.

Participants were informed about the nature of the study and what findings needed to be obtained and thus informed consent was obtained. The participants were provided with the rights to voluntarily consent or decline to participate, and to withdraw at any time without penalty. Privacy and anonymity were ensured as the name of the participants or any form of identity was not required.

RESULTS

As shown in Table 1, participant's age shows that 56% were between 24-28 years while 66.5%were Yoruba by tribe, 96.7% were married and 55.5% had up to tertiary education.

Table 1: Socio demographic data of the respondents

SOCIO-DEMOGRAPHIC DATA		FREQUENCY (n=182)	PERCENTAGES (%)
AGE DISTRIBUTION	19-23	12	5.6
	24-28	102	56.0
	29-33	49	26.9
	34 and above	19	10.4
SOCIOCULTURAL GROUP	Yoruba	121	66.5
	Hausa	4	2.2
	Igbo	17	9.3
	Others	40	22.0
RELIGION	Christianity	133	73.1
	Islam	31	17.0
	Traditional	18	9.9
MARITAL STATUS	Single	5	2.7
	Married	176	96.7
	Co-habiting	-	-
	Divorced	1	0.5
	Widowed	-	-
EDUCATIONAL LEVEL	Never educated	2	1.1
	Primary	38	20.9
	Secondary	41	22.5
	Tertiary	101	55.5
OCCUPATION	Student	55	30.2
	Artisan	21	11.5
	Civil servant	51	28.0
	Trader	39	21.4
	Unemployed	16	8.8
FAMILYTYPE	Monogamous	156	85.7
	Polygamous	26	14.3

With respect to the religious beliefs of mothers during pregnancy and labour, 78.6% strongly agreed that God is the ultimate midwife while 52.7% indicated that God can deliver them safely without antenatal, 33.5% believe the use of anointing oil or other drinks from my religious leaders are more effective than hospital prescribed drugs while 21.4% strongly agreed that the laboring process is easier in maternity homes belonging to their faith (Table 2).

Table 2: Assessment of religious beliefs in pregnancy and labour

Question	SA	A	D	SD
	F %	F %	F %	F %

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God is the ultimate midwife	143 78.6	31 17.0	8 4.4	-
I believe God can deliver me safely without ante-natal	96 52.7	40 22.0	23 12.6	23 12.6
I believe anointing oil/drink from my religious leaders are more effective than hospital prescribed drugs	61 33.5	13 7.1	71 39.0	37 20.3
I believe in the healing/treatment outcomes of my faith than the hospital	33 18.1	41 22.5	81 44.5	27 14.8
The laboring process is easier in maternity homes belonging to my faith	39 21.4	12 6.6	30 16.5	101 55.5
Complications or successful delivery, all outcomes are God's will	52 28.6	80 44.0	17 9.3	33 18.1
My faith does not believe in surgical delivery (Caesarian section)	23 12.6	29 15.9	77 42.3	53 29.1

Table 3 shows the religious practices in pregnancy and labour. Findings revealed that 16.5% of the participants strongly agreed that they will avoid taking some foods flagged as "unclean" by their faith even if recommended by doctors but over 90% of participants strongly disagreed with the practice of fasting by pregnant women.

Table 3: Assessment of religious practices in pregnancy and labour

Question	SA	A	D	SD
	F %	F %	F %	F %
I attend the weekly vigil in my place of worship	6 3.3	1 0.5	100 54.9	75 41.2
I avoid taking some foods flagged as "unclean" by my faith even if recommended by doctors	30 16.5	17 9.3	96 52.7	39 21.4
I participate in the weekend evangelism that involves trekking every week	-	-	48 26.4	134 73.6
I read books and periodicals about my faith	111 61.0	61 33.5	4 2.2	6 3.3
My religion forbids another man even if he were a doctor to touch me as a woman	-	-	161 88.5	21 11.5
Religion is especially important because it answers many questions about the meaning of life	109 59.9	51 28.0	6 3.3	16 8.8
The prayers I say when I am alone carried as much meaning and personal emotion as those said by me during services	58 31.9	78 42.9	40 22.0	6 3.3
If I were to join a social religious group, I would do this just to learn my religion better rather than for a social fellowship	91 50.0	35 19.2	27 14.8	29 15.9
I fast most times even during pregnancy	3 1.6	-	89 48.9	90 49.5

Table 4 displays the faith related barriers to utilizing maternal healthcare services, 41.8% of the participants indicated that do not have enough information about the birth process. Almost all (96.7%) the participants indicated that their culture permits hospital delivery while 34.1% admitted they cannot do what they were told at the hospital as long as it contradicts their faith.

Table 4: Faith-related barriers to utilizing maternal health care services

Question	Yes	No
	F %	F %

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My faith does not allow the use of modern birth process and so I stick with the traditional ways	3 1.6	179 98.4
My husband and I cannot afford the ante-natal care	7 3.8	175 96.2
It is a taboo in my religion that I get naked before another man even if it were a male doctor	2 1.1	180 98.9
I do not have enough information about the birth process	76 41.8	106 58.2
We are very far to modern health care ante-natal facilities and services	21 11.5	161 88.5
My family does not believe in the modern birth methods	2 1.1	180 98.9
My culture does not permit hospital delivery	6 3.3	176 96.7
My culture does not permit other forms of laboring process except the traditional means	4 2.2	176 97.8
I cannot do what I am told to do in antenatal if my religion says otherwise	62 34.1	120 65.9
I could not get adequate care as my religion forbids the use of orthodox medicine	4 2.2	176 97.8

In general, the study revealed nil significant relationship (p= .016) between age of women and religious related practices in pregnancy. Table 5 shows the relationship between age of post-partum women and religious related practices.

Table 5: Relationship between age of post-partum women and religious related practices

AGE OF WOMEN		PREGNANCY-RELATED RELIGIOUS PRACTICES			TOTAL	P VALUE
		Poor	Fair	Good		
19-23	Count	2	7	3	12	0.016
	% within age	16.7%	58.3%	25.0%	100.0%	
24-28	Count	5	84	13	102	
	% within age	4.9%	82.4%	12.7%	100.0%	
29-33	Count	6	31	12	49	
	% within age	12.2%	63.3%	24.5%	100.0%	
34 and above	Count	4	9	6	19	
	% within age	21.1%	47.4%	31.4%	100.0%	
TOTAL	Count	17	131	34	182	
	% within age	9.3%	72.0%	18.7%	100.0%	

With respect to relationship between the level of education of post-partum women and utilization of maternal health services, no significant relationship (p= .260) was observed (Table 6).

Table 6: Relationship between level of education and utilization of maternal health care services

LEVEL OF EDUCATION		UTILIZATION OF MATERNAL HEALTH CARE SERVICES			TOTAL	P VALUE
		Poor	Fair	Good		
Never educated	Count	-	2	-	2	0.260
	% within educational level	-	100.0%	-	100.0%	
Primary	Count	9	17	12	38	

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	% within educational level	4.9%	82.4%	12.7%	100.0%	
Secondary	Count	4	21	16	41	
	% within educational level	12.2%	63.3%	24.5%	100.0%	
Tertiary	Count	7	44	49	101	
	% within educational level	21.1%	47.4%	31.4%	100.0%	
TOTAL	Count	20	84	77	182	
	% within educational level	11.0%	46.2%	42.3%	100.0%	

DISCUSSION OF FINDINGS

The socio-demographic characteristics of participants shows that more than half of the respondents were between the age of 24-28 years which is similar to a study conducted by (Ghodrati*et al*., 2018) where 51.4% of the respondents were between 21-25 years of age. Almost all (96.7%) the participants were married. This finding was in line with a previous study where majority (81.8%) were married (Haileyesus*et al*., 2018). With regards to participants educational level, more than half (55.5%) had tertiary education this differs from the findings of (Haileyesus*et al*., 2018) who conducted a similar study but 44% of their participants had no formal education while 66.6% were full housewives unlike this study where only 8.8% were unemployed.

Findings on participants' religious beliefs during pregnancy and labour shows that 78.6% strongly agreed that God is the ultimate midwife while more than half also believed that God can deliver them safely without antenatal care. These findings are similar to a previous study where participants referred to God as the Supreme Being who is in control of the world and all it contains (Ohaja, Murphy-Lawless, & Dunlea, 2019). About one-third of the of the participants believed in the efficacy of anointing oil and other drinks from their religious leaders over orthodox medicines. This is similar to a study conducted by (Aziato *et al*. 2016) in Ghana where women also believed in anointing oil, blessed water, blessed white handkerchief, blessed sand, Bible and Rosary to provide a favourable pregnancy outcome.

Some of the participants also indicated that laboring process is easier in maternity homes belonging to their faith and pregnancy outcomes that are successful or complicated are purely God's will. These findings were consistent with previous study whereparticipants made reference to praying to or thanking God for a positive pregnancy outcome (Linhares, 2012). Praying for and with women is a powerful way of addressing women's religious and spiritualneeds. This was confirmed by participants in a similar study (Aziato *et al*., 2016). Likewise, midwives in a descriptive study by (Linhares, 2012) reported actively using prayer as a tool when supporting women during birth.

With regards to the participants' religious practices in pregnancy and labour, few (16.5%) indicated that they will avoid taking some foods termed unclean by their faith even if such foods are recommended by doctors. This finding was in line with previous study where it was revealed that some beliefs and practices include food and water restrictions during pregnancy (Heidari, Ziaei, Ahmadi, Mohammadi, & Hall, 2015; Elter, Kennedy, Chesla, & Yimyam, 2016).Specific dietary restrictions such as avoidance of fish in diet may predispose the pregnant woman to dietary deficiencies (Heidari*et al*., 2015). More than half of mothers in the study strongly agreed they read books and periodicals about their faith and expressed the importance of religion to human existence as it answers many questions of life. This finding is consistent with previous study where the importance of religion to human existence especially in the African context was buttressed (Sampson, 2014; Akeredolu *et al*., 2017).

Concerning participants' faith related barriers to the utilization of maternal healthcare services, almost all participants indicated that their faith/cultures allowed for hospital delivery although about one-third

mentioned that they will disobey health instructions that contradict their faith. Few participants also admitted they could not afford antenatal care services while some mentionedthe distance from modern health care facilities as a barrier. These findings are consistent with previous study where it was revealed that a number of constraining factors impact on the uptake of maternal health services, such as harmful traditional practices, costs of services (in terms of time, money and loss of labor), poor quality of care as well as negative attitudes of healthcare providers (Elter*et al*., 2016).

CONCLUSION

The study has highlighted significant findings in religious beliefs and practices among post-partum mothers in the study settings. Majority of the participants expressed that God is the ultimate midwife, participants beliefs in prayers, some are of the opinion that even without antenatal care God is sufficient enough to deliver them safely. Some of the mothers also indicated that anointing oil as well as other drinks from their religious leaders are more effective than hospital prescribed drugs. While some belief that the process of childbirth is easier in faith/religious maternity homes. Almost all participants disagreed with the practice of fasting during pregnancy and all participants mentioned that their families, cultures and faith allows for hospital delivery.

RECOMMENDATIONS

Based on the findings from this study, there is need for consistent programmes aimed at sensitizing women, especially prospective mothers on the importance of a skilled birth attendant during labour. Couples as well as the community at large should be sensitized on the importance of maternal and child health services so as to ensure hospital deliveries thereby, saving the lives of mothers and their unborn babies, which we consequently reduce maternal and child morbidity and mortality rates.

Policy makers and healthcare providers should actively involve religious and traditional leaders in reproductive health of women. They should be encouraged to positively support their followers and encourage them on the utilization of health care facilities especially during pregnancy and childbirth.

Lastly, midwives and other healthcare provider should be re-educated on the topics of religion and spirituality so as to help them in providing comprehensive holistic care, thus, ensuring that no aspect of care is ignored.

LIMITATIONS OF STUDY

The study was limited to women attending postnatal clinics in the two selected health centres in Ado-Ekiti hence, the findings of the study may not be generalized.

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CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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