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PHENOMENOLOGICAL STUDY OF SUPERSTITIOUS BELIEFS AND MENTAL WELL-BEING AMONG PREGNANT WOMEN

Qualitative Study

Ayesha Jabbar[1]*, M. Qamar U Siyam[2], Shujia Hassan[2], M. Abdullah[1], Tauseef Ahmad[1], Sameen Sadaqat[3]*, Fatima Siddique[2], Osheen Kaniz[2], Fatima Saeed[4]

[1]Lecturer, University of Okara

[2]University of Okara

[3]Lahore College for Women University

[4]Government Special Education School, Renala Khurd

Corresponding Author: Ayesha Jabbar*, ayeshajabbar50@gmail.com, Lecturer, University of Okara; Sameen Sadaqat*, sameen.sadaqat@gmail.com, Lahore College for Women University

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ABSTRACT

Background: Superstitious beliefs during pregnancy are prevalent in many cultures, especially in regions where traditional customs strongly influence maternal behaviors. These beliefs, often passed down through generations, can shape how women manage their pregnancy, sometimes supporting well-being but at times interfering with evidence-based care. In Pakistan, cultural heritage, religious norms, and limited access to maternal healthcare services contribute to the persistence of these beliefs, which may affect maternal and fetal outcomes if not addressed through informed, culturally sensitive approaches.

Objective: To explore the nature, origin, and impact of pregnancy-related superstitions among women from different regions of Pakistan, and to identify the cultural, psychological, and societal factors that contribute to their persistence.

Methods: This qualitative study employed a phenomenological design and purposive sampling to select eight pregnant women from five regions of Punjab: Pakpatan, Sahiwal, Okara, Haveli Lakha, and Faisalabad. In-depth, semi-structured interviews were conducted in private settings. The audio-recorded data were transcribed verbatim, coded, and analyzed using thematic analysis. Thematic categorization followed a structured approach, identifying core themes and sub-themes related to cultural beliefs, emotional responses, and social influences.

Results: Four major themes and ten sub-themes were derived from the data. Among the eight participants (aged 18–40), 62.5% had only primary education, and 75% belonged to lower socioeconomic groups. Codes such as food taboos (n=11), fear and anxiety (n=10), and reliance on elders (n=8) were highly recurrent. Religious practices (n=4), generational differences (n=6), and lack of health literacy (n=6) also emerged as significant factors influencing beliefs. Most women preferred traditional advice over medical counsel due to emotional security, community pressure, and accessibility issues.

Conclusion: Superstitious beliefs during pregnancy are deeply ingrained in Pakistani culture, influenced by family traditions, religious values, and socioeconomic limitations. To promote safe maternal health, healthcare strategies must integrate culturally respectful education, family-centered counseling, and collaboration with traditional influencers and medical professionals.

Keywords: Cultural heritage, Maternal health, Pakistan, Pregnancy, Psychological factors, Religious influence, Superstitious beliefs

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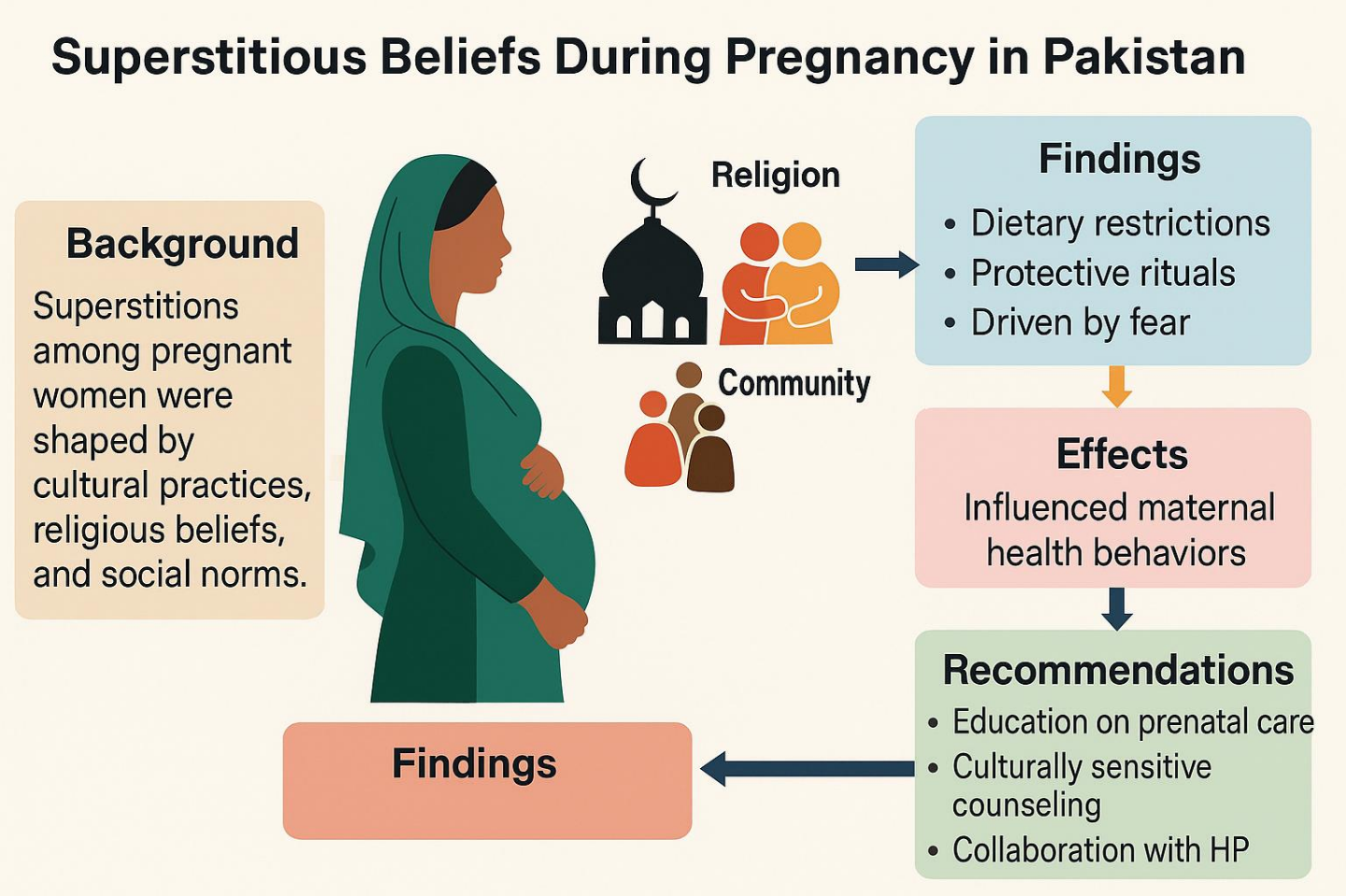

INTRODUCTION

Superstitions have long been embedded within cultural traditions across the globe, influencing individuals' behaviors, beliefs, and decisions often without conscious awareness (1). These beliefs are frequently inherited through generations and shaped by religious teachings, social norms, and fears, and they persist because of their deep cultural roots and emotional comfort (2). One area where such beliefs are particularly prevalent is pregnancy—a time marked by both hope and uncertainty. In many societies, including Pakistan, women are surrounded by a complex web of superstitions that dictate what they should eat, how they should behave, and which rituals they must follow to ensure the safety of themselves and their unborn child (3). These practices, though sometimes rooted in benign intentions, can have unintended consequences on maternal and child health, especially when they replace or delay evidence-based medical interventions (4). Across various regions, pregnancy-related superstitions include avoiding certain foods believed to cause birth defects, performing rituals to ward off evil, and abstaining from attending funerals or visiting graveyards out of fear of misfortune (5). In some communities, items such as red threads are tied around a pregnant woman's wrist to protect against malevolent forces, while others advise staying indoors during eclipses or avoiding the sight of disabled individuals, fearing negative influence on the unborn baby (3,6). These practices reflect an underlying need for control during a time when many aspects of a woman's health feel unpredictable. In Pakistan, such beliefs are often reinforced by community elders and midwives, especially in rural and marginalized settings where access to modern maternal care is limited (7).

The persistence of these beliefs can be attributed to several factors, including cultural heritage, psychological vulnerability during pregnancy, and lack of access to healthcare services (2,8). For many women, particularly those from low socioeconomic backgrounds,

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superstitions offer a sense of security and familiarity in the face of medical uncertainty (9). Moreover, when healthcare systems fail to reach these women effectively, they tend to fall back on traditional knowledge, even when it lacks scientific credibility (10). This reliance is further perpetuated by the belief that "if it worked for our ancestors, it must still hold value today" (5). However, the consequences of such practices are not always benign. Avoiding nutritious foods due to food taboos can lead to vitamin and mineral deficiencies, impacting fetal development and increasing the risk of complications such as preterm birth or low birth weight (11). Additionally, women who rely solely on traditional beliefs may delay or forgo essential antenatal checkups, risking undiagnosed conditions such as gestational diabetes, preeclampsia, or infections, which remain major contributors to maternal and neonatal mortality in South Asia (12,13). The psychological burden of adhering to these expectations also compounds stress and anxiety during pregnancy, further complicating maternal mental health outcomes (3).

Despite significant advancements in medical science, superstitions remain influential, particularly in countries with strong cultural continuity like Pakistan. While some traditional beliefs—such as encouraging rest or emotional well-being—may align with modern recommendations, others hinder timely medical intervention and optimal maternal care (5,14). To address this, health professionals advocate for culturally sensitive education strategies that bridge the gap between traditional belief systems and scientific maternal healthcare (15). Engaging community influencers like elders, midwives, and religious leaders can foster trust and facilitate gradual shifts in behavior without alienating communities (6,8). Additionally, involving family members, especially male partners, in educational campaigns has shown to improve support systems and health-seeking behaviors among expectant mothers (3,10). Ultimately, addressing the impact of pregnancy-related superstitions is crucial for improving maternal and neonatal health outcomes. This requires not only acknowledging the socio-cultural factors that sustain these beliefs but also implementing targeted, respectful, and evidence-based interventions to mitigate their potential risks. The objective of this study is to assess the prevalence of pregnancy-related superstitions among women in Pakistan, investigate their cultural and psychological origins, and evaluate their implications on maternal health practices and outcomes.

METHODS

The study employed a qualitative phenomenological research design to explore the cultural, psychological, and social dimensions influencing superstitious beliefs among pregnant women in Pakistan. This approach was chosen to gain a deeper understanding of participants' lived experiences and the contextual factors surrounding these beliefs. A mixed-methods framework was integrated to supplement broader quantitative insights, although the current phase emphasized qualitative data collection through in-depth interviews. Purposive sampling was utilized to recruit eight participants representing diverse geographical locations, ethnic backgrounds, socioeconomic statuses, and educational levels. The inclusion criteria involved pregnant women willing to share their experiences with cultural and superstitious practices related to pregnancy. Women with known psychiatric disorders or cognitive impairments that could hinder meaningful communication were excluded to maintain the reliability and depth of the data. Efforts were made to ensure a representative sample from both rural and urban communities to capture a wide spectrum of cultural influences.

Data were collected using semi-structured, in-depth interviews conducted in a private and comfortable setting to ensure participants felt at ease and willing to speak freely. An interview protocol comprising open-ended questions was developed to explore themes such as food taboos, ritual practices, religious influences, family traditions, and emotional responses. Each interview was audio-recorded with the participant's informed consent and subsequently transcribed verbatim for analysis. The data collection process emphasized confidentiality, autonomy, and the voluntary nature of participation. Ethical approval for the study was obtained from the Institutional Review Board (IRB) of the respective academic institution. All participants provided written informed consent, and their identities were anonymized in the transcripts and final report to ensure privacy. Thematic analysis was employed to analyze the qualitative data. This involved systematic coding of the transcripts, identifying recurring patterns, and grouping them into broader thematic categories. Themes were refined through iterative readings and researcher triangulation to ensure credibility and minimize bias. The thematic analysis allowed for the identification of core influencing factors such as cultural rituals, community expectations, stress coping mechanisms, and misconceptions surrounding pregnancy. The study acknowledged and maintained ethical standards in line with the Declaration of Helsinki. Participants were briefed in detail about the study's objectives, and their right to withdraw at any time was respected throughout. All responses were treated with sensitivity, and only aggregated findings were reported to maintain anonymity.

RESULTS

This phenomenological study explored superstitious beliefs during pregnancy among eight participants selected through purposive sampling, representing diverse demographic backgrounds including age (18 to 40 years), educational levels (primary to graduate), socioeconomic status (lower to upper-middle), and geographical locations (Faisalabad, Pakpatan, Haveli, and Sahiwal). Four major themes and ten sub-themes emerged from thematic analysis of transcribed interviews, supported by participant observations and focus group discussions. The first major theme, *Cultural Beliefs and Practices*, revealed sub-themes including cultural diversity and ethnic

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influences, religious practices, and inter-generational transfer. Food taboos and ethnic customs were notably frequent, with food-related codes mentioned 11 times. One participant remarked,

"ہمارے ہاں کہا جاتا ہے کہ حمل کے دوران گوشت اور مچھلی زیادہ کھانے سے بچے کے جسم پر داغ پڑتے ہیں، تو میں نے پورے نو مہینے ان چیزوں سے پرہیز کیا۔"

Religious influences were also prominent, mentioned 4 times. Practices such as reciting specific Quranic chapters during pregnancy were emphasized:

"میری امّی نے کہا تھا کہ سورہ یوسف اور سورہ مریم روز پڑھو تاکہ بچہ خوبصورت اور نیک ہو۔"

Inter-generational transmission was reinforced by older family members, who served as custodians of traditional norms (cultural transfer code frequency = 2). The second theme, *Prevalence of Superstitions*, encompassed common superstitious beliefs (mentioned 8 times) and generational differences (6 times). Participants shared a range of inherited practices meant to protect the unborn child. For instance, one woman stated,

"میری دادی کہتی تھیں کہ پہلے زمانے میں لوگ ان باتوں پر عمل کرتے تھے، اب کی لڑکیاں نافرمان ہو گئی ہیں۔ میں نے دادی کی بات کا لحاظ رکھا۔"

These findings highlight tensions between traditional norms and modern skepticism, especially among younger, educated women.

The third and most frequent theme, *Psychological and Social Factors*, included fear and anxiety (10 times), emotional reliance on traditions (3), literacy and awareness (6), and socioeconomic status (7). Many women expressed fear linked to eclipses, spirits, and omens during pregnancy. A participant noted,

"بہت دفعہ ڈر لگتا تھا، خاص طور پر جب گرہن ہوتا تھا۔ میں نے سنا تھا کہ گرہن کے وقت سوئی دھاگہ نہ پکڑو، ورنہ بچے پر نشان آتا ہے، تو میں خود کو کمرے میں بند کر لیتی تھی۔"

This psychological vulnerability reinforced dependence on traditional guidance for emotional reassurance. Another participant shared,

"میں خود تو زیادہ نہیں پڑھی، لیکن جو میری نند ہے وہ کافی پڑھی لکھی ہے، وہ کہتی ہے کہ یہ سب باتیں غلط ہیں، لیکن میں نے بچپن سے سنا ہے، اس لیے یقین کرتی ہوں۔"

Literacy and education emerged as differentiating factors in belief systems. Socioeconomic limitations further influenced decisions, as expressed by one participant:

"ہمارے ہاں زیادہ تر لوگ غریب ہیں، ڈاکٹر کے پاس جانے کی بجائے بزرگوں کے بتائے ٹوٹکے ہی کرتے ہیں۔ وہ سستے بھی ہیں اور آسان بھی۔"

Peer review and participant validation strengthened the trustworthiness of the analysis. Academic experts in maternal health and cultural studies confirmed the appropriateness of theme categorization, while participants acknowledged that the identified themes genuinely reflected their experiences. Some participants contributed additional insights, emphasizing evolving attitudes toward superstitions among younger generations.

The themes and subthemes derived from the data are listed below:

Major Themes – Sub-Themes – Initial Codes

Cultural Beliefs and Practices

- Cultural Diversity & Ethnic Influences – Food taboos, ethnic influences
- Religious Practices – Religious practices
- Inter-generational Transfer – Transmission of beliefs

Prevalence of Superstitions

- 2.1 Common Superstitious Beliefs – Superstitions
- 2.2 Generational Differences – Differences in beliefs by age

Psychological and Social Factors

- 3.1 Anxiety & Fear – Fear, anxiety
- 3.2 Emotional Dependency on Traditions – Reliance on traditional practices
- 3.4 Literacy & Awareness – Literacy levels, lack of awareness
- 3.5 Socioeconomic Status – Impact of SES

Table 1*:* Demographic information of participants for qualitative analysis (N=8)

Participants	Age	Education	SES	Geographic
1	18 years	Intermediate	Upper-Middle	Faisalabad
2	24 years	Graduated	Middle	Pakpatan
3	25 years	Intermediate	Upper-Middle	Haveli
4	33 years	Graduated	Upper-Middle	Sahiwal
5	40 years	Primary	Lower	Sahiwal
6	34 years	Primary	Lower	Pakpatan
7	35 years	Primary	Lower	Pakpatan
8	32 years	Primary	Lower	Sahiwal

Table 2: Major Themes, Sub-Themes, and Initial Codes Derived from Data

Major Themes	Sub-Themes	Initial Codes
Cultural Beliefs and Practices	1.1 Cultural Diversity & Ethnic Influences	Food taboos ethnic influences
	1.2 Religious Practices	Religious practices
Prevalence of Superstitions	2.1 Common Superstitious Beliefs	Superstitions
	2.2 Generational Differences	Generational differences in beliefs
Psychological and Social Factors	3.1 Anxiety & Fear	Fear and anxiety
	3.2 Emotional Dependency on Traditions	Emotional reliance on traditional practices
	3.4 Literacy & Awareness	Literacy levels, lack of awareness
	3.5 Socioeconomic Status	Impact of socioeconomic status

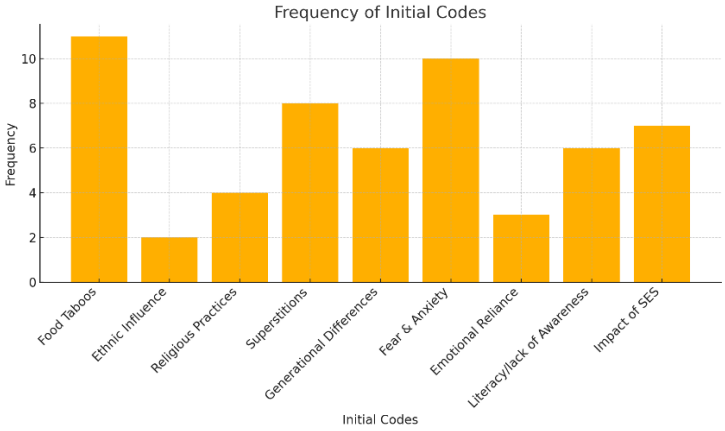
Table 3: An overview of derived themes and subthemes.

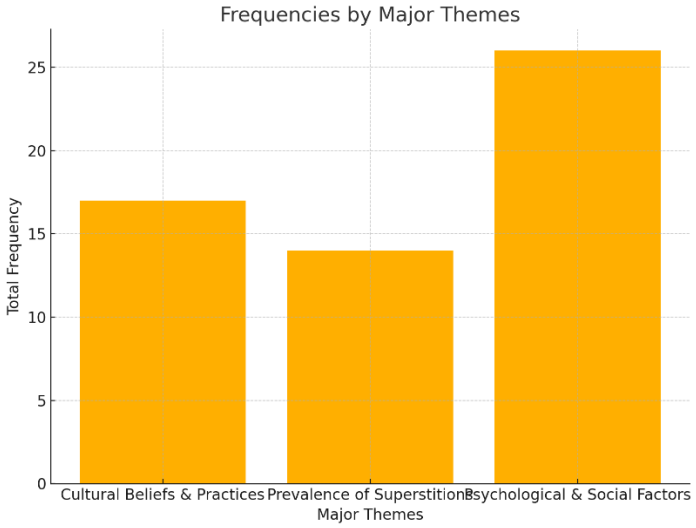
Cultural Beliefs and Practices	1.1 Cultural Diversity & Ethnic Influences
	1.2 Religious Practices
	1.3 Inter-generational Transfer
Prevalence of Superstitions	2.1 Common Superstitious Beliefs
	2.2 Generational Differences
Psychological and Social Factors	3.1 Anxiety & Fear
	3.2 Emotional Dependency on Traditions
	3.4 Literacy & Awareness
	3.5 Socioeconomic Status

Table 4: Initial Codes Frequency

Initial codes	Frequency *f*	Major Themes
Food Taboos	11	Cultural Beliefs & practices
Ethnic Influence	2	
Religious Practices	4	
Superstitions	8	Prevalence of Superstitions

Generational Differences	6	
Fear & Anxiety	10	Psychological & Social Factors
Emotional Reliance	3	
Literacy/ lack of Awareness	6	
Impact of SES	7	





DISCUSSION

The findings of this study provide compelling insight into the widespread prevalence of superstitious beliefs among pregnant women in Pakistan, emphasizing the significant influence of cultural, psychological, and societal factors. The data revealed that many women adhered to specific rituals, such as avoiding particular foods and engaging in protective practices, which were shaped by longstanding family traditions, community norms, and emotional coping mechanisms. These results align with previous literature indicating that traditional health beliefs often gain prominence in societies where biomedical resources are limited or underutilized (16). Superstitions in this context serve not only as a cultural framework but also as a psychological tool to navigate the uncertainties of pregnancy. A notable theme in the current study was the intergenerational transmission of beliefs. Elder family members, particularly grandmothers and mothers-in-law, were observed to play a central role in reinforcing these practices. This pattern has also been documented in other cultural settings where elders function as custodians of knowledge, thereby perpetuating traditional customs across generations (17). These beliefs provided emotional comfort and reduced anxiety among participants, particularly those from rural or resource-constrained settings. Such reliance on inherited knowledge reflects the deep-rooted need for perceived control in a period marked by physical, emotional, and existential vulnerability.

Psychologically, superstitious behavior during pregnancy appears to be underpinned by heightened anxiety and fear, especially in communities with limited access to formal health education. Participants often expressed fear of supernatural consequences, which led them to adopt avoidance behaviors and ritualistic practices. This psychological pattern can be conceptually framed within cognitive theories such as heuristic thinking and belief perseverance, where emotionally significant experiences override logical reasoning. Women often reported anecdotal validations from their community, further reinforcing these beliefs despite the lack of scientific evidence. This psychological coping mechanism finds parallels in broader literature, where traditional beliefs function as self-protective responses in unpredictable health situations (18,19). The study also highlighted the significant role of socioeconomic disparities. Women from lower-income groups demonstrated stronger adherence to superstitions, which correlated with limited access to education and healthcare services. These findings are consistent with global research underscoring the relationship between socioeconomic deprivation and reliance on traditional belief systems (20). Rural settings, in particular, showed a stronger adherence to superstition, likely due to the lack of maternal healthcare infrastructure and sustained exposure to traditional narratives. In contrast, more educated participants from urban areas exhibited a greater degree of skepticism, suggesting that health literacy plays a critical role in mediating belief systems.

While the prevalence and impact of these superstitions have been well documented in this study, the results also affirm that not all traditional practices are detrimental. Some customs—such as encouraging rest, promoting emotional well-being, and restricting strenuous activities—are consistent with modern obstetric recommendations (21). However, the challenge lies in discerning between practices that support maternal health and those that hinder it, such as dietary restrictions that lead to nutritional deficiencies or the

avoidance of medical consultation due to fear of bad luck. The practical implications of these findings are considerable for maternal healthcare policy and practice (22). Healthcare providers should approach these beliefs with cultural sensitivity and empathy, avoiding outright dismissal of traditions that hold emotional value for patients. Respectful engagement with community figures such as elders, traditional birth attendants, and religious leaders can facilitate the integration of evidence-based medical advice within culturally relevant frameworks. Educational programs tailored to local languages and beliefs may further bridge the gap between scientific knowledge and traditional health behaviors, fostering a more collaborative approach to maternal care (23).

The study presents several strengths, including the use of in-depth qualitative interviews that allowed for a comprehensive understanding of the sociocultural context in which these beliefs are sustained. The diversity in the sample, which included women from varying age groups, educational backgrounds, and geographic locations, contributed to a nuanced exploration of the phenomenon. The use of thematic analysis, peer validation, and participant review enhanced the credibility and trustworthiness of the findings. Nevertheless, certain limitations must be acknowledged. The reliance on self-reported data introduces the possibility of social desirability bias, as participants may have withheld information or framed responses to align with perceived expectations. The relatively small sample size and regional focus limit the generalizability of the findings to broader populations across Pakistan. Recruitment challenges, especially in areas where traditional beliefs are particularly strong, may have constrained the diversity of perspectives. Moreover, while the study explores belief systems in detail, it does not directly quantify their effects on clinical health outcomes such as birth weight, antenatal visit frequency, or maternal morbidity, which could be valuable in evaluating the tangible risks associated with harmful superstitions.

Future research should address these gaps by incorporating mixed-method designs that integrate qualitative narratives with quantitative assessments of maternal health indicators. Longitudinal studies could explore how superstitious beliefs evolve across multiple pregnancies or in response to increasing exposure to health education. Cross-regional and cross-cultural comparisons may also illuminate universal psychological mechanisms underlying belief systems while revealing context-specific expressions. Additionally, future studies should include a broader demographic scope, encompassing varied religious and ethnic groups, to provide a more representative understanding of how superstitions function in maternal healthcare across Pakistan and similar contexts. In conclusion, this study contributes to the growing body of literature on cultural influences in maternal health by illuminating the psychological, social, and structural underpinnings of superstitious beliefs during pregnancy. By recognizing the nuanced role these beliefs play in shaping behavior, health systems can design more effective, respectful, and inclusive strategies to improve maternal outcomes without alienating the cultural frameworks that women rely upon for support and reassurance.

CONCLUSION

This study concluded that superstitious beliefs during pregnancy remain deeply rooted in cultural traditions and emotional coping mechanisms, often providing comfort yet potentially influencing important health decisions. These beliefs persist across generations, especially in communities with limited access to education and healthcare. The findings highlight the need for healthcare providers to approach maternal care with cultural sensitivity, fostering trust through respectful dialogue and education. By acknowledging the role of tradition while promoting evidence-based practices, healthcare systems can support pregnant women in making informed choices that safeguard both their well-being and that of their unborn children.

AUTHOR CONTRIBUTIONS

Author	Contribution
Ayesha Jabbar	Conceptualization, Methodology, Formal Analysis, Writing - Original Draft, Validation, Supervision
M. Qamar U Siyam	Methodology, Investigation, Data Curation, Writing - Review & Editing
Shujia Hassan	Investigation, Data Curation, Formal Analysis, Software
M. Abdullah	Software, Validation, Writing - Original Draft
Tauseef Ahmad	Formal Analysis, Writing - Review & Editing
Sameen Sadaqat	Writing - Review & Editing, Assistance with Data Curation
Fatima Siddique	Software, Validation, Writing - Original Draft
Osheen Kaniz	Formal Analysis, Writing - Review & Editing
Fatima Saeed	Writing - Review & Editing, Assistance with Data Curation

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