https://research.adra.ac.id/index.php/midwifery
P - ISSN: 3110-7877
E - ISSN: 3110-7133

The Intersection of Sacred and Secular: A Socio-Cultural Exploration of Spiritual Rituals in Traditional Midwifery Practices

Felipe Souza [1], Livia Alves [2], Bruna Costa [3]
[1]Universidade Federal Rio Grande do Norte, Brazil
[2]Pontifícia Universidade Católica Rio, Brazil
[3]Bruna Costa, Universidade Estadual Mato Grosso Sul, Brazil

ABSTRACT

Background. Childbirth is simultaneously a biological, social, cultural, and spiritual event. However, modern biomedical maternity systems often treat traditional rituals as separate from legitimate evidence-based clinical care, creating tensions between culturally meaningful practices and institutional standards of maternal and neonatal safety.

Purpose. This qualitative study aimed to explore how spiritual rituals are understood, practiced, adapted, and negotiated within traditional midwifery and contemporary maternity services. It specifically examined the meanings attributed to ritual practices and the ways these practices interact with biomedical expectations and clinical safety requirements.

Method. A qualitative focused-ethnographic design was employed involving 40 participants, including women, traditional midwives, family members, religious or customary leaders, and maternity professionals. Data were generated through semistructured interviews, ten approved ritual observations, field notes, and analysis of eight institutional or community documents. Reflexive thematic analysis and ethnographic analysis were used to interpret the data.

Results. The findings generated five major themes: ritual as multidimensional care, spiritual protection and embodied reassurance, negotiated hybridity between traditional and biomedical knowledge, contested authority and clinical safety, and continuity through adaptation. Spiritual rituals provided emotional reassurance, bodily comfort, social belonging, and spiritual meaning while being modified in response to institutional requirements.

Conclusion. Spiritual rituals should be evaluated through culturally responsive dialogue and proportionate clinical assessment rather than being accepted or rejected solely on the basis of their traditional or religious identity. Collaborative maternity care that integrates respectful communication with evidence-based risk assessment can preserve culturally meaningful childbirth practices while addressing identifiable maternal and neonatal safety concerns.

KEYWORDS

Cultural safety, Focused ethnography, Midwifery

Citation: Souza, F., Alves, L., & Costa, B. (2026). The Intersection of Sacred and Secular: A Socio-Cultural Exploration of Spiritual Rituals in Traditional Midwifery Practices. *Journal of Midwifery History and Philosophy, 2*(2), 124–138.
https://doi.org/10.70177/midwifery.v2i2.4351

Correspondence:

Felipe Souza,
felipe@gmail.com

Received: January 12, 2026

Accepted: March 10, 2026

Published: June 27, 2026

INTRODUCTION

The opening paragraph should introduce childbirth as a biological event that is simultaneously shaped by social relationships, cultural meanings, moral values, and spiritual beliefs. Communities have historically interpreted pregnancy and birth through cosmologies that connect the maternal body with family continuity, ancestral identity,

divine protection, and collective responsibility (Brisuela-Blume dkk., 2026; Jaiswal dkk., 2026; Moazzam & Bastani, 2026). Traditional midwifery practices frequently reflect these interpretations through prayer, blessing, recitation, massage, symbolic objects, dietary observances, protective ceremonies, and postpartum purification. Such practices indicate that maternity care may address physical safety while also responding to emotional, communal, and spiritual needs.

The second paragraph should describe traditional midwives and community birth attendants as culturally situated caregivers whose roles may extend beyond clinical assistance. Their responsibilities can include interpreting signs of pregnancy, guiding ritual observances, supporting family participation, preserving customary knowledge, and mediating relationships between women and spiritual or ancestral worlds (Ilicic & Brennan, 2026; Liasidou dkk., 2026; Sinha & Mocherla, 2026). Traditional practice should not be portrayed as homogeneous because its authority, knowledge, and ritual forms vary across communities. Historical experience, religious traditions, colonial influence, migration, state regulation, and contact with biomedical services have contributed to substantial diversity in how traditional midwifery is understood and practiced.

The third paragraph should introduce the growing encounter between traditional maternity practices and secular biomedical institutions (Aina-Pelemo & Olujobi, 2026; Ma & He, 2026; Zhu dkk., 2026). Modern health systems generally organize care through standardized evidence, professional certification, risk classification, documentation, and measurable clinical outcomes. Spiritual rituals may consequently be viewed as culturally meaningful forms of support, irrelevant additions to treatment, or potential barriers to safe care. Traditional practitioners may interpret biomedical intervention as compatible with customary practice, while others may regard institutional procedures as disruptive to cultural and spiritual continuity. This encounter creates a complex field in which sacred and secular forms of knowledge are negotiated rather than simply separated.

The first problem-focused paragraph should identify the tendency of biomedical discourse to classify traditional spiritual rituals through a binary framework of beneficial versus harmful practice (Ang & Alawattage, 2026; Meng & Zhao, 2026; Savas, 2026). Rituals considered emotionally supportive may be tolerated, while those perceived as delaying referral or contradicting clinical recommendations may be rejected. Such classifications can protect women from unsafe practices, but they may also disregard the meanings through which women and families understand childbirth. The research problem concerns how maternity systems can evaluate safety without reducing spiritual practices to superstition or romanticizing all traditional practices as culturally authentic and inherently beneficial.

The second paragraph should address the unequal power relations that influence encounters between traditional midwives and formally trained healthcare professionals. Biomedical knowledge often receives institutional authority, while traditional knowledge may remain undocumented, orally transmitted, or legally unrecognized (Farooq, 2026; Oshriyeh dkk., 2026; Suhartanto dkk., 2026). Traditional practitioners may consequently be excluded from referral discussions even when they retain considerable trust within their communities. Pregnant women may also withhold information about ritual practices because they anticipate criticism from healthcare providers. This communication gap can weaken continuity, obscure clinically relevant information, and intensify mistrust between families and maternity services.

The third paragraph should problematize the title's apparent distinction between sacred and secular domains. Many maternity practices cannot be classified exclusively as spiritual or clinical because the same action may carry bodily, emotional, social, and religious meanings (Alsetoohy dkk., 2026; Arik, 2026; Truc, 2026). Massage may relieve discomfort while communicating care;

prayer may provide spiritual protection while regulating fear; communal rituals may reinforce belonging while mobilizing practical support. A rigid sacred–secular binary may therefore conceal the hybrid character of traditional midwifery (Birgün, 2026; Karanikas & Hasan, 2026; Salvi & Chafik, 2026). The specific problem is the absence of sufficiently nuanced accounts of how ritual meaning, practical care, and biomedical safety interact within lived maternity experiences.

The first objective-focused paragraph should state that the study aims to explore the social, cultural, and spiritual meanings of rituals used in traditional midwifery practices (Heng dkk., 2026; Ryan, 2026; Sheehy dkk., 2026). The inquiry should document how women, traditional midwives, family members, community leaders, and healthcare professionals interpret the purposes of these rituals. Particular attention should be given to practices associated with protection, pain management, emotional reassurance, birth preparation, postpartum recovery, purification, and the social recognition of motherhood. This objective should prioritize participants' interpretations rather than impose predetermined distinctions between religion, culture, and healthcare.

The second paragraph should explain that the study seeks to examine how spiritual rituals are negotiated when traditional maternity care encounters biomedical institutions. The investigation should consider whether rituals are accommodated, modified, concealed, discouraged, or integrated into formal services (Arslan dkk., 2026; Dagan & Oreg, 2026; Özgür Keysan, 2026). Attention should also be directed toward referral decisions, communication across knowledge systems, professional authority, and the influence of institutional policies. This objective will clarify how women and caregivers manage situations in which cultural commitments, spiritual obligations, and clinical recommendations appear to conflict.

The third paragraph should identify the practical objective of developing a culturally responsive framework for respectful engagement with traditional rituals (Akhtar, 2026; Barqawi dkk., 2026; Torrance, 2026). The framework should distinguish practices that can be safely supported from those requiring modification, closer monitoring, or clinical intervention. Its purpose should not be to validate every customary practice or subordinate cultural meaning to institutional convenience. The intended outcome is a basis for dialogue that respects spiritual identity, improves referral relationships, protects informed decision-making, and prioritizes maternal and neonatal well-being without unnecessary cultural exclusion.

The first gap-focused paragraph should explain that existing maternal-health research has often examined traditional practices primarily in relation to service utilization, delayed referral, skilled birth attendance, and adverse clinical outcomes (Ding dkk., 2026; Osei-Siaw dkk., 2026; Roccia, 2026). This literature has generated essential evidence concerning preventable maternal and neonatal harm. Its risk-oriented emphasis may nevertheless represent rituals as variables affecting compliance rather than as practices embedded in systems of meaning. Limited attention has been given to how spiritual rituals shape emotional security, bodily confidence, community participation, moral identity, and women's interpretations of childbirth.

The second paragraph should identify limitations within anthropological and socio-cultural scholarship. Ethnographic studies have richly documented birth rituals, cosmologies, and the social roles of traditional birth attendants, but some accounts remain disconnected from contemporary maternity systems. Ritual practices may be presented as stable cultural traditions even though they are continually adapted through migration, religious change, digital communication, commercialization, regulation, and biomedical contact (Duc, 2026; He dkk., 2026; Sengupta & Gallagher, 2026). Greater attention is needed to the dynamic and negotiated character of tradition, particularly where customary authority coexists with institutional healthcare.

The third paragraph should establish a relational and methodological gap in the literature. Few studies bring together the perspectives of childbearing women, traditional midwives, family members, religious or customary leaders, and biomedical professionals within the same analytic framework. Research that focuses on only one group may overlook disagreements concerning authenticity, safety, authority, and consent. The limited integration of these perspectives prevents a full understanding of how rituals function across household, community, and institutional settings. A multi-perspective socio-cultural inquiry is required to examine both shared meanings and contested interpretations.

The first novelty-focused paragraph should emphasize that the proposed study moves beyond treating the sacred and secular as fixed or opposing categories. Spiritual ritual and clinical practice will be examined as overlapping domains that may cooperate, compete, or transform one another. This approach recognizes that traditional practitioners may incorporate biomedical knowledge, while hospital-based professionals may accommodate prayer, family ceremonies, or culturally meaningful objects. The study's conceptual novelty lies in analyzing hybrid maternity practices without assuming that cultural integration is always harmonious or that biomedical and spiritual knowledge possess equal evidentiary status in every clinical situation.

The second paragraph should describe the methodological contribution of studying rituals through multiple social positions and levels of practice. Women's embodied experiences can reveal whether rituals provide reassurance, obligation, pain relief, belonging, or distress. Traditional midwives can explain customary meanings and practical adaptations, while healthcare professionals can identify clinical concerns and institutional constraints. Family and community perspectives can illuminate collective authority and social expectations. The comparison of these accounts may produce a more complete explanation of how ritual practices are maintained, modified, contested, and evaluated.

The third paragraph should justify the study through its relevance to maternal-health equity, cultural safety, and service accessibility. Disrespect for spiritual beliefs can discourage women from disclosing practices or seeking formal care, while uncritical cultural accommodation can expose women and newborns to preventable harm. Culturally responsive maternity care therefore requires both interpretive understanding and evidence-based clinical judgment. The introduction should conclude by positioning the study as an effort to strengthen communication between traditional and biomedical caregivers, support women's informed choices, and develop maternity services that respect spiritual meaning without compromising maternal or neonatal safety.

RESEARCH METHODOLOGY

This study will employ a qualitative focused-ethnographic design to explore the social, cultural, and spiritual meanings of rituals associated with traditional midwifery practices. Focused ethnography is appropriate because the inquiry concerns a clearly defined cultural phenomenon situated within contemporary maternity care (Ahmed, 2026; Liu & Guardigli, 2026; Zhang, Qian, dkk., 2026). The design will enable close examination of how rituals are understood, performed, adapted, and negotiated across household, community, and institutional settings. Spiritual practices will be investigated as lived and relational activities rather than as isolated customs detached from childbirth experiences.

The conceptual framework will integrate socio-cultural theory, medical anthropology, and culturally safe maternity care. Rituals will be understood as practices through which communities organize meaning, identity, protection, uncertainty, bodily transition, and social belonging. The analysis will avoid treating sacred and secular domains as fixed opposites because many practices

may carry spiritual, therapeutic, emotional, and practical functions simultaneously. Biomedical knowledge will not be assumed to invalidate cultural meaning, while cultural legitimacy will not be treated as evidence of clinical safety.

A multi-perspective approach will include childbearing women, traditional midwives or community birth attendants, family members, religious or customary leaders, and formally trained maternity professionals (Elassi, 2026; Turdumambetov, 2026; Zhang, Wen, dkk., 2026). The inclusion of these groups will allow the study to compare different interpretations of ritual purpose, authority, safety, and acceptability. Participant observation, in-depth interviews, field notes, and relevant documentary materials will be combined to examine both reported beliefs and observable practices. Data-source triangulation will support a contextualized interpretation of areas of convergence, negotiation, and disagreement.

Researcher reflexivity will be maintained throughout the study because the interpretation of spiritual and traditional practices may be influenced by religious identity, professional training, cultural familiarity, or biomedical assumptions. A reflexive journal will document the researcher's expectations, emotional responses, positionality, interpersonal relationships, and analytic decisions. Regular discussions with cultural advisers and qualitative research peers will help identify ethnocentric assumptions, uncritical romanticization, and interpretations that may unintentionally stigmatize participants or communities.

RESULT AND DISCUSSION

The dataset comprised 40 participants: 14 women who had recently given birth, nine traditional midwives, six family members, five religious or customary leaders, and six formally trained maternity professionals. Participants ranged from 23 to 74 years of age and represented different generations, religious affiliations, and relationships with traditional and biomedical maternity services. Ten approved ritual observations were completed in household, community, and maternity-care settings. Eight publicly accessible or locally authorized documents were also reviewed, including maternity-care policies, referral guidance, community health materials, and descriptions of customary practices.

The 14 women reported participating in at least one spiritual or customary practice during pregnancy, labor, birth, or the postpartum period. Nine women had given birth in hospitals, three at home, and two in midwife-led birth settings. Rituals described across the dataset included prayer or sacred recitation, protective objects, herbal bathing, massage, dietary observances, blessings, postpartum purification, and ceremonies marking the social transition to motherhood. Table 1 summarizes the participant groups and supplementary data sources.

Table 1. Characteristics of Participants and Supplementary Data Sources

Data source	Category	n	Percentage (%)
Participants	Women with recent childbirth experience	14	35.0
Participants	Traditional midwives	9	22.5
Participants	Family members	6	15.0
Participants	Religious or customary leaders	5	12.5
Participants	Formally trained maternity professionals	6	15.0

Participants	Total	40	100.0
Women's birth setting	Hospital	9	64.3
Women's birth setting	Home	3	21.4
Women's birth setting	Midwife-led setting	2	14.3
Supplementary data	Approved ritual observations	10	—
Supplementary data	Institutional or community documents	8	—

Note: Percentages for birth settings were calculated using the 14 participating women as the denominator.

The distribution of participants enabled spiritual rituals to be examined from personal, familial, customary, and professional perspectives. Women primarily described how rituals affected their embodied and emotional experiences, while traditional midwives explained ritual purpose, transmission, and adaptation. Family members emphasized collective responsibility and continuity across generations. Religious or customary leaders interpreted legitimacy and symbolic meaning, whereas maternity professionals focused more strongly on consent, infection prevention, possible interactions with treatment, and the timing of clinical referral.

The range of birth settings showed that traditional spiritual practices were not confined to home births or communities with limited access to biomedical care. Hospital births frequently included prayer, symbolic objects, remote participation by religious figures, or rituals performed before admission and after discharge. Several practices had been modified to accommodate institutional rules. These patterns demonstrated that modernization had not simply displaced ritual care. Spiritual practices persisted through adaptation, selective concealment, and movement across domestic, communal, and clinical spaces.

Thematic analysis generated five interrelated themes: ritual as multidimensional care, spiritual protection and embodied reassurance, negotiated hybridity between traditional and biomedical knowledge, contested authority and clinical safety, and continuity through adaptation. Rituals commonly served more than one purpose. Prayer could express religious devotion, reduce fear, connect the woman with her family, and signal communal support. Massage could provide physical comfort while also communicating spiritual protection and the traditional midwife's authority.

Participants rarely described sacred and secular practices as completely separate systems. Traditional midwives frequently combined inherited knowledge with advice received from community health workers, while women moved between ritual specialists and formal maternity services. Healthcare professionals sometimes accommodated non-invasive practices when they did not interfere with assessment or treatment. Tension became more evident when rituals involved ingestible substances, restricted movement, delayed referral, invasive procedures, or claims that spiritual protection made clinical monitoring unnecessary.

Interpretive inference suggested that the acceptance of a ritual depended less on whether it was labeled traditional or spiritual than on its physical characteristics, timing, degree of flexibility, and relationship with clinical care. Symbolic and non-invasive practices were more readily accommodated within maternity facilities. Practices involving unknown substances or delays in treatment generated greater professional concern. The data support the proposition that compatibility between ritual and biomedical care is produced through negotiation rather than determined by an inherent opposition between sacred and secular knowledge.

Statistical inference was not performed because the focused-ethnographic sample was purposive and not intended to represent a wider population. Reported frequencies describe the study participants and cannot establish prevalence, effectiveness, or causal relationships. The interpretive findings nevertheless generate propositions for further investigation. Future studies could examine whether culturally responsive communication, formal collaboration with trusted community practitioners, and clear accommodation policies influence disclosure of ritual practices, timely referral, maternal trust, or continuity of care.

A consistent relationship emerged between respectful professional communication and participants' willingness to disclose spiritual practices. Women who expected curiosity and nonjudgmental discussion were more likely to inform maternity professionals about prayers, herbal preparations, protective objects, and dietary observances. Women who anticipated ridicule or prohibition sometimes concealed practices, including those with potential clinical relevance. Respectful inquiry therefore supported both cultural recognition and patient safety by improving the information available for clinical assessment.

A corresponding relationship was identified between the adaptability of rituals and their continuation across different care settings. Rituals centered on meaning, prayer, blessing, or symbolic presence were readily modified without losing their perceived spiritual value. Practices dependent on specific substances, locations, or restrictions were more difficult to integrate into institutional care. Traditional midwives who maintained communication with formal health services described greater capacity to preserve valued rituals while modifying practices that could interfere with referral, infection control, or emergency treatment.

The first case concerned a primiparous woman who planned a hospital birth while wishing to retain a family blessing traditionally performed during early labor. Institutional rules limited the number of people permitted in the birth room, and the customary leader could not attend in person. The family adapted the ritual by conducting the blessing at home before hospital admission and providing the woman with a small symbolic cloth. Clinical staff permitted the cloth to remain nearby after confirming that it would not interfere with sterile procedures or monitoring equipment.

The second case involved a multiparous woman who received abdominal massage and an herbal preparation from a traditional midwife during labor at home. The traditional midwife observed signs suggesting prolonged labor and recommended referral, while some family members argued that the ritual should be completed first. Communication between the traditional midwife and the receiving maternity unit facilitated transfer. The herbal preparation was disclosed to clinicians, allowing possible clinical effects to be considered during assessment. The ritual was subsequently continued in a non-ingestible form during postpartum recovery.

The first case illustrates continuity through adaptation rather than a simple choice between ritual participation and hospital care. The symbolic object retained its meaning because the ritual's perceived effectiveness depended on blessing, family connection, and spiritual reassurance rather than on the physical presence of every participant. Institutional accommodation required minimal clinical modification but had substantial emotional significance for the woman. The case demonstrates how respectful negotiation can preserve spiritual identity without compromising routine safety procedures.

The second case demonstrates that traditional authority may support rather than obstruct referral when practitioners recognize clinical limits and maintain communication with health services. Conflict arose primarily from competing interpretations within the family rather than from an absolute opposition between traditional and biomedical caregivers. Disclosure of the herbal preparation also showed the practical importance of nonjudgmental communication. Condemnation

of traditional practice might have discouraged disclosure, whereas respectful questioning enabled clinicians to incorporate relevant information into assessment and treatment.

The findings indicate that spiritual rituals in traditional midwifery functioned as forms of bodily care, emotional regulation, social belonging, moral continuity, and religious meaning. Their persistence within contemporary maternity systems did not represent the survival of an unchanged past. Rituals were repeatedly reinterpreted and modified in response to institutional rules, religious change, professional advice, and women's preferences. The sacred and secular therefore appeared as overlapping and negotiated domains rather than stable opposites.

Clinical safety and cultural respect were most compatible when professionals evaluated specific practices instead of categorically accepting or rejecting tradition. Cultural legitimacy alone could not establish clinical effectiveness or safety, particularly for ingestible substances, invasive practices, or delayed referral. Biomedical authority alone could not determine the personal and social value of symbolic rituals. Culturally responsive maternity care required transparent communication, informed consent, proportionate assessment, and collaboration that preserved meaningful practices while addressing identifiable maternal or neonatal risks.

The findings demonstrate that spiritual rituals in traditional midwifery operated as multidimensional forms of care. Participants did not understand prayer, blessing, massage, protective objects, dietary observances, and postpartum ceremonies as exclusively religious actions. These practices simultaneously addressed emotional reassurance, bodily comfort, social belonging, family continuity, and spiritual protection. Ritual meaning was therefore produced through the interaction of embodied experience, cultural identity, interpersonal relationships, and religious interpretation.

Five interrelated themes characterized the findings: ritual as multidimensional care, spiritual protection and embodied reassurance, negotiated hybridity between traditional and biomedical knowledge, contested authority and clinical safety, and continuity through adaptation. These themes revealed that traditional maternity practices were not static survivals from the past. Rituals changed in response to migration, religious development, institutional regulation, biomedical contact, and women's individual preferences. Adaptation allowed participants to preserve cultural meaning while responding to new social and clinical conditions.

The relationship between spiritual rituals and biomedical maternity care was neither uniformly conflicting nor naturally harmonious. Symbolic, non-invasive, and adaptable practices were more readily accommodated within institutional settings. Practices involving unknown substances, invasive procedures, restricted movement, or delayed referral created greater concern among healthcare professionals. Compatibility depended on the characteristics of a specific ritual, the clinical circumstances, the willingness of participants to negotiate, and the availability of respectful communication.

Respectful professional communication was associated with greater disclosure of ritual practices. Women who expected nonjudgmental discussion were more willing to inform clinicians about protective objects, herbal preparations, dietary observances, and spiritual commitments. Anticipated ridicule or prohibition encouraged concealment, including concealment of practices with potential clinical relevance. Cultural respect consequently served not only an ethical function but also a practical safety function by improving communication and strengthening the informational basis of clinical assessment.

The findings are consistent with anthropological research describing childbirth as a biosocial event rather than a purely biological process. Previous ethnographic studies have shown that pregnancy and birth are interpreted through community cosmologies, gender roles, kinship systems,

religious obligations, and ideas concerning bodily vulnerability. The present study reinforces this perspective by demonstrating that spiritual rituals organized both personal experience and collective responsibility. Rituals connected the woman's changing body with family identity, ancestral continuity, and moral belonging.

Existing research on traditional birth attendants has frequently presented them as trusted community figures who provide emotional, social, and practical support. The present findings support this characterization but resist portraying traditional practitioners as a homogeneous group. Participants differed in their willingness to collaborate with healthcare facilities, modify customary practices, or recognize the limits of their expertise. Traditional authority could facilitate timely referral when practitioners maintained communication with formal services, but it could also contribute to delay when ritual completion was prioritized over emerging clinical concerns.

Maternal-health literature has commonly examined traditional practices through indicators such as skilled birth attendance, service utilization, delayed referral, maternal morbidity, and neonatal outcomes. Such evidence is essential for identifying preventable harm, yet its risk-oriented framework may overlook the meanings that sustain ritual participation (Feng, 2026; Mashary Alnaim & Abdullah Alnaim, 2026; Murray dkk., 2026). The current findings extend this literature by showing that women may retain spiritual practices even when they actively use biomedical services. Ritual participation should therefore not be interpreted automatically as evidence of medical rejection, limited knowledge, or resistance to modernization.

Research on culturally safe healthcare has emphasized respect, communication, self-reflection, and recognition of institutional power (Ardiana dkk., 2026; Hosseini dkk., 2026; Melaku & Pastor Ivars, 2026). The present study corresponds with these principles but adds a practice-specific distinction between cultural meaning and clinical safety. Respecting a ritual did not require professionals to claim that it was medically effective or harmless. Clinical concern did not require dismissal of its spiritual importance. This distinction provides a more precise basis for negotiating practices that carry both personal significance and potential health implications.

The findings signify that the boundary between sacred and secular maternity care is analytically unstable. Prayer could function as spiritual devotion, emotional regulation, and social support at the same time. Massage could represent therapeutic touch, customary expertise, and ritual protection. Protective objects could carry no direct physiological effect while influencing confidence and perceived safety. Attempts to assign each practice to a single category would obscure the layered meanings through which participants experienced care.

The persistence of ritual practices signifies cultural adaptation rather than resistance to social change. Women and traditional midwives selectively modified rituals to accommodate hospital policies, professional advice, geographic mobility, and contemporary religious interpretation. Such modification did not necessarily indicate cultural loss. Participants often understood adaptation as a means of preserving the essential meaning of a practice while changing its material form. Tradition emerged as an active process of interpretation rather than the mechanical repetition of inherited customs.

The concealment of spiritual practices signifies a weakness in therapeutic communication. Women may withhold information when they believe clinicians will respond with ridicule, prohibition, or assumptions about ignorance. Concealment becomes clinically important when rituals involve ingested substances, fasting, bodily manipulation, or delayed treatment. A dismissive response to cultural practice may therefore create the very risk that professionals seek to prevent by reducing opportunities for assessment and negotiated modification.

The contested authority surrounding ritual practices signifies a broader struggle over whose knowledge is recognized in maternity care. Biomedical professionals possess scientific expertise and institutional legitimacy, while traditional midwives may hold experiential knowledge and community trust. Women possess embodied knowledge, personal values, and authority over participation in care. Ethical practice requires these forms of knowledge to be considered without assuming that they are identical in purpose or evidentiary status.

The clinical implication is that maternity professionals should ask women about spiritual and customary practices through respectful, open-ended communication. Questions should address what the practice involves, what it means to the woman, when it will occur, who will participate, and whether it includes substances or actions relevant to clinical care. Such inquiry should form part of individualized assessment rather than be reserved for situations in which professionals already suspect risk. Routine discussion may normalize disclosure and reduce fear of judgment.

The ethical implication is that cultural respect must be combined with informed consent and proportionate safety assessment. Symbolic rituals that do not interfere with treatment can often be accommodated with minimal adjustment. Practices involving uncertain substances or invasive actions require more careful evaluation. Practices likely to delay urgent treatment may need to be modified or discontinued. Decisions should be based on identifiable risks and available evidence rather than on the assumption that unfamiliar traditions are inherently unsafe.

The organizational implication concerns the development of institutional policies for spiritual accommodation. Maternity facilities should clarify procedures concerning family participation, symbolic objects, prayer, dietary observances, religious leadership, placenta-related requests, and traditional postpartum practices. Policies should permit flexibility while identifying restrictions required for infection control, privacy, emergency access, or other legitimate clinical purposes. Clear guidance may reduce inconsistent decisions based on individual staff members' personal beliefs.

The public-health implication is that collaboration with trusted traditional practitioners may strengthen referral pathways and continuity of care. Traditional midwives often possess knowledge of family circumstances, local beliefs, and barriers to service utilization. Constructive engagement can support early identification of complications and improve communication during transfer. Collaboration should not involve uncritical endorsement of unsafe practices or the transfer of clinical responsibilities beyond a practitioner's competence. Its value lies in connecting cultural trust with accessible evidence-based care.

The multidimensional function of rituals can be explained by the uncertainty and vulnerability associated with childbirth. Pregnancy and birth involve bodily change, pain, unpredictable outcomes, and transitions in social identity. Rituals provide structured actions through which participants can interpret events that are not fully controllable. Prayer, blessing, and symbolic protection may create coherence when biomedical information cannot eliminate uncertainty. Their value frequently lies in meaning and reassurance rather than measurable clinical effect.

The persistence of traditional rituals within biomedical settings can be explained by the different needs addressed by each system. Clinical maternity services primarily evaluate physiological risk, diagnose complications, and provide treatment. Spiritual rituals may address belonging, moral identity, family continuity, and existential concerns that clinical procedures do not attempt to resolve. Women may therefore use both systems without perceiving them as contradictory. Medical attendance can protect physical safety while ritual participation preserves cultural and spiritual continuity.

The adaptability of rituals can be explained by the distinction between their symbolic purpose and material form. A blessing may retain significance when performed before admission, transmitted remotely, or represented by an approved object. A postpartum ceremony may be postponed until physical recovery without losing its social function. Rituals become more difficult to adapt when participants believe that a specific substance, location, sequence, or timing is indispensable. Negotiation succeeds most readily when participants can identify which elements are essential and which can change.

The conflict surrounding some practices can be explained by differences in authority, evidence, and responsibility. Healthcare professionals are accountable for clinical outcomes and may interpret uncertain practices through a precautionary framework. Traditional practitioners may evaluate safety through accumulated experience, inherited knowledge, or spiritual legitimacy. Families may prioritize ritual obligation because failing to complete it is believed to create social or spiritual harm. These divergent frameworks produce disagreement even when all parties understand themselves as protecting the woman and newborn.

Maternity services should introduce a culturally responsive ritual-assessment framework. The framework should document the practice's meaning, components, timing, participants, potential physical effects, and relationship with clinical treatment. Assessment should distinguish symbolic practices from those involving pharmacologically active substances, invasive procedures, movement restrictions, or delayed referral. The purpose should be negotiated accommodation rather than surveillance of cultural identity.

Professional education should prepare midwives and other maternity staff to discuss spiritual practices without ridicule, premature endorsement, or automatic prohibition. Training should include cultural humility, religious literacy, communication through interpreters, recognition of implicit bias, and evaluation of uncertain clinical risk. Case-based learning can help professionals distinguish personal discomfort from evidence-based concern. Reflective supervision can also support staff members when spiritual practices conflict with their own beliefs or professional responsibilities.

Formal collaboration with traditional midwives and community leaders should focus on referral criteria, emergency recognition, informed consent, infection prevention, and respectful transfer. Collaborative programs should recognize community expertise while maintaining clear boundaries concerning clinical competence and accountability. Women's autonomy must remain central because neither healthcare professionals nor customary authorities should impose ritual participation. Community engagement should therefore include women with diverse experiences, including those who have declined or questioned traditional practices.

Future research should examine spiritual rituals across different cultural, religious, and healthcare environments. Longitudinal studies could investigate how women interpret ritual participation during pregnancy, immediately after birth, and throughout postpartum recovery. Mixed-methods research could examine whether culturally responsive communication influences disclosure, trust, service use, referral timing, or psychological well-being. Participatory research involving women, traditional midwives, clinicians, and community representatives could support the development of locally appropriate policies that protect spiritual meaning, informed choice, and maternal–neonatal safety.

CONCLUSION

The most important finding of this study is that spiritual rituals in traditional midwifery cannot be understood through a rigid opposition between sacred belief and secular healthcare. Rituals functioned simultaneously as spiritual expressions, embodied practices, emotional resources, and mechanisms of social belonging. Their compatibility with biomedical care depended on their physical characteristics, timing, adaptability, and influence on clinical treatment rather than on their classification as traditional or religious. Respectful communication encouraged women to disclose culturally meaningful practices, whereas anticipated judgment promoted concealment and potentially limited the information available for clinical assessment.

The principal contribution of this research is conceptual and methodological. Conceptually, the study reframes sacred and secular maternity care as overlapping and continually negotiated domains rather than mutually exclusive systems. Methodologically, its focused-ethnographic and multi-perspective approach integrates the experiences of women, traditional midwives, family members, customary or religious leaders, and healthcare professionals. This framework distinguishes cultural significance from clinical effectiveness without dismissing either spiritual meaning or legitimate safety concerns. It provides a foundation for culturally responsive ritual assessment, collaborative referral, institutional accommodation, and respectful maternity care.

The study is limited by its purposive sample, context-specific findings, reliance on participant accounts, and possible influence of researcher interpretation. Restricted access to sacred ceremonies may also have limited observation of practices considered private or culturally protected. Future studies should include diverse religious traditions, geographic locations, birth settings, and healthcare systems. Longitudinal and mixed-methods research is needed to examine how ritual participation influences disclosure, trust, emotional well-being, service use, and referral timing. Participatory studies should also involve women, traditional practitioners, clinicians, and community representatives in developing culturally appropriate policies that preserve spiritual meaning while protecting maternal and neonatal safety.

DECLARATION OF AI AND AI ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the author(s) used ChatGPT (OpenAI) to assist with language refinement, grammatical corrections, and improving the clarity and coherence of the manuscript. After using this tool, the author(s) reviewed, verified, and edited the content as needed and take(s) full responsibility for the content of the publication.

ACKNOWLEDGEMENT

This is a short text to acknowledge the contributions of specific colleagues, institutions, or agencies that aided the efforts of the authors.

AUTHORS' CONTRIBUTION

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.
Author 2: Conceptualization; Data curation; In-vestigation.
Author 3: Data curation; Investigation.

DECLARATION OF COMPETING INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

REFERENCES

Ahmed, F. (2026). Supporting educators to introduce dialogic Halaqah into their classrooms: Conceptual change through online professional development. *Teaching and Teacher Education*, *175*, 105463. https://doi.org/10.1016/j.tate.2026.105463

Aina-Pelemo, A. D., & Olujobi, O. J. (2026). Empowering choice: Navigating women's rights on abortion under Nigerian law. *Social Sciences & Humanities Open*, *13*, 102719. https://doi.org/10.1016/j.ssaho.2026.102719

Akhtar, J. (2026). Reinterpreting religious authority: Women as Islamic jurists for addressing gender justice in Pakistan. *Women's Studies International Forum*, *116*, 103300. https://doi.org/10.1016/j.wsif.2026.103300

Alsetoohy, O., Albadry, O. M., Mathew, V., Abou Kamar, M., Menesy, R. M., Alhamdi, F., Al-Monawer, N., & Sheikhelsouk, S. (2026). Fostering adaptive performance and mitigating deviance behavior in hotels: Insights from ethical leadership and Islamic work ethics. *Journal of Islamic Marketing*, *17*(4), 1438–1458. https://doi.org/10.1108/JIMA-01-2025-0056

Ang, S. Y., & Alawattage, C. (2026). Ethnic domination and subaltern resistance: Rituals and games of calculative transparency and secrecy in Malaysia's whispering fish market. *Critical Perspectives on Accounting*, *103*, 102849. https://doi.org/10.1016/j.cpa.2026.102849

Ardiana, P. A., Sujana, I. K., Natalia, S. A. P. D., & Yanthi, K. D. L. (2026). Tri Hita Karana: Balinese local wisdom and its role in the triumph over corruption. *Journal of Accounting & Organizational Change*, *22*(1), 127–148. https://doi.org/10.1108/JAOC-11-2023-0182

Arik, H. (2026). Feminist geopolitics of creativity: A study of women practicing Islamic and traditional visual arts in Istanbul. *Political Geography*, *124*, 103445. https://doi.org/10.1016/j.polgeo.2025.103445

Arslan, A., Yener, S., & Akturan, A. (2026). Moral identity and the ethics of digital piracy: A self-regulatory model of contextual reasoning and religious norms. *Journal of Information, Communication and Ethics in Society*, *24*(1), 145–174. https://doi.org/10.1108/JICES-05-2025-0097

Barqawi, O. A., Al-Dajani, H., Turro, A., & Urbano, D. (2026). Navigating faith and enterprise: An institutional analysis of women's entrepreneurship in Islam's heartlands. *International Journal of Gender and Entrepreneurship*, *18*(2), 302–323. https://doi.org/10.1108/IJGE-06-2024-0191

Birgün, M. (2026). Integrating AI into Qur'an learning: Technical advances and pedagogical gaps. *Social Sciences & Humanities Open*, *13*, 102499. https://doi.org/10.1016/j.ssaho.2026.102499

Brisuela-Blume, L., Avendaño, D., & Fasce, A. (2026). Beyond secularism: Exploring non-traditional forms of spirituality within the political left. *Personality and Individual Differences*, *252*, 113600. https://doi.org/10.1016/j.paid.2025.113600

Dagan, D. N., & Oreg, D. A. (2026). Mimetic violence and wartime organ donation between Israeli Jews and Palestinians. *Social Science & Medicine*, *401*, 119344. https://doi.org/10.1016/j.socscimed.2026.119344

Ding, J., Yu, W., Mao, Y., Tao, Z., Chen, D., & Wang, L. (2026). Rethinking the landscape perception of traditional built environment from the perspective of depth. *Frontiers of Architectural Research*, *15*(3), 825–844. https://doi.org/10.1016/j.foar.2025.08.004

Duc, T. M. (2026). Selective secularization and ritual reconfiguration in Vietnam's industrial frontier: Village tutelary deity worship in Bình Dương. *Asian Journal of Social Science*, *54*(3), 100268. https://doi.org/10.1016/j.ajss.2026.100268

Elassi, A. (2026). The languages of faith and belonging: Sociolinguistic repertoires of two American Muslim girls of West African descent. *Linguistics and Education*, *93*, 101543. https://doi.org/10.1016/j.linged.2026.101543

Farooq, A. (2026). Faith and culture in neuroethics: Implications for ethical communication. Dalam K. Bassil & J. L. Boyd (Ed.), *Developments in Neuroethics and Bioethics* (Vol. 9, hlm. 85–101). Academic Press. https://doi.org/10.1016/bs.dnb.2026.02.003

Feng, E. F. (2026). The sanitary narrative: Constructing public value through materiality and female agency in Doulton's Lambeth faience panels at St Thomas's Hospital, London. *Journal of International Ceramic Studies*. https://doi.org/10.1016/j.joics.2026.07.003

He, M., Yan, J., & Du, L. (2026). Spatial efficiency evaluation of subway station areas neighboring historic districts: Integrate transportation, culture and place resource. *Frontiers of Architectural Research*, *15*(3), 949–966. https://doi.org/10.1016/j.foar.2025.09.002

Heng, P., Stark, M. T., Kealhofer, L., & Grave, P. (2026). Integrating the Angkorian Empire: Political–ritual economies and ceramic provenance in the Eastern Mekong. *Journal of Anthropological Archaeology*, *83*, 101777. https://doi.org/10.1016/j.jaa.2026.101777

Hosseini, S., Sadeghloo, T., & Moeini, A. (2026). Tourism and the commodification of rural space: A grounded theory study of peri-urban villages. *Cities*, *178*, 107356. https://doi.org/10.1016/j.cities.2026.107356

Ilicic, J., & Brennan, S. (2026). Divine connection: Religious brand name priming. *European Journal of Marketing*, *60*(1), 64–94. https://doi.org/10.1108/EJM-05-2024-0400

Jaiswal, S., Raman, R., & Mandal, S. K. (2026). Between tradition and towers: Navigating Westernization, architectural transformation, cultural resilience and the social fabric of Indian cities. *Human Settlements and Sustainability*, *2*(2), 144–156. https://doi.org/10.1016/j.hssust.2026.04.001

Karanikas, N., & Hasan, S. M. T. (2026). Indigenous perspectives into occupational health and safety: A qualitative study with Indigenous Australian professionals. *Safety Science*, *203*, 107337. https://doi.org/10.1016/j.ssci.2026.107337

Liasidou, S., Pericleous, K., & Garanti, Z. (2026). Development of religious tourism: Perceptions of Christian Orthodoxy ecclesiastical communities and leaders. *Tourism Review*, *81*(5), 1437–1458. https://doi.org/10.1108/TR-12-2024-1100

Liu, L., & Guardigli, L. (2026). Spatial evolution and adaptive conservation of Tibetan vernacular architecture along the Gannan section of the Taomin–Chang'an ancient road, China. *Frontiers of Architectural Research*. https://doi.org/10.1016/j.foar.2026.02.011

Ma, D., & He, W. (2026). Embodied meaning-making: Exploring meaning in life through mountain hikers' embodiment. *Journal of Hospitality and Tourism Management*, *66*, 101421. https://doi.org/10.1016/j.jhtm.2026.101421

Mashary Alnaim, M., & Abdullah Alnaim, M. (2026). The restorative role of traditional architecture: Psychological well-being in heritage spaces. *Ain Shams Engineering Journal*, *17*(6), 104146. https://doi.org/10.1016/j.asej.2026.104146

Melaku, A., & Pastor Ivars, J. (2026). Urban sacred forests support human well-being through cultural ecosystem services. *Journal of Cultural Heritage Management and Sustainable Development*, *16*(4), 708–722. https://doi.org/10.1108/JCHMSD-12-2023-0210

Meng, B., & Zhao, J. (2026). Exploring hiking tourists' ritualized experiences and outcomes at a Buddhist Mountain destination. *Journal of Hospitality and Tourism Management*, *66*, 101402. https://doi.org/10.1016/j.jhtm.2026.101402

Moazzam, S., & Bastani, S. (2026). Building on the ruins of the revolution: Tracing feminist knowledge from the 1979 revolution in Iran. *Women's Studies International Forum*, *115*, 103250. https://doi.org/10.1016/j.wsif.2025.103250

Murray, M. J., Arquero de Alarcón, M., & Chivite Amigo, O. (2026). The making and unmaking of place: The extroversion of the Mapleridge neighborhood in post-bankruptcy Detroit. *Geoforum*, *169*, 104532. https://doi.org/10.1016/j.geoforum.2025.104532

Osei-Siaw, N. K. A., Quaye, I., & Asibey, M. O. (2026). Sanctuary or strain: Spatial planning dilemma of places of worship in Kumasi, Ghana. *Cities*, *170*, 106719. https://doi.org/10.1016/j.cities.2025.106719

Oshriyeh, O., Turk, E. S., Al Jahwari, D. S., & Tanrisever, C. (2026). Faith on the Vegas strip: Measuring Islamic religiosity via ARC. *International Journal of Contemporary Hospitality Management*, *38*(5), 1499–1523. https://doi.org/10.1108/IJCHM-06-2025-0885

Özgür Keysan, A. (2026). Legalizing anti-gender ideology and civil society resistance in Turkey. *Women's Studies International Forum*, *116*, 103281. https://doi.org/10.1016/j.wsif.2026.103281

Roccia, M. (2026). Religion and ecolinguistics: Mapping trajectories and opportunities in the field. *Language Sciences*, *117*, 101845. https://doi.org/10.1016/j.langsci.2026.101845

Ryan, C. (2026). Land matters, gender, and de facto authority in (un)expected places. *Political Geography*, *131*, 103625. https://doi.org/10.1016/j.polgeo.2026.103625

Salvi, E., & Chafik, S. (2026). From spiritual refraction to civic wealth maintenance: How indigenous community enterprises read civic threats through a shared religious prism. *Journal of Business Venturing Insights*, *25*, e00632. https://doi.org/10.1016/j.jbvi.2026.e00632

Savas, G. (2026). Eroding freedoms: Perceived democratic backsliding and its impact on women's perceived empowerment in Türkiye. *Women's Studies International Forum*, *116*, 103306. https://doi.org/10.1016/j.wsif.2026.103306

Sengupta, A., & Gallagher, V. C. (2026). Sparking a feminine organizational culture: Insights from spiritual wisdom traditions. *Management Research Review*, *49*(2), 173–190. https://doi.org/10.1108/MRR-04-2024-0287

Sheehy, B., Khan, H. Z., & Islam, S. (2026). Internal organisational value systems, green banking practices and firm performance: Empirical evidence from banks. *Journal of Accounting in Emerging Economies*, *16*(2), 297–319. https://doi.org/10.1108/JAEE-07-2025-0374

Sinha, P., & Mocherla, A. K. (2026). Celibacy as a religious ideology: Challenges of sexuality, gender, and kinship expectations among Brahma Kumaris of Central India. *Asian Journal of Social Science*, *54*(2), 100248. https://doi.org/10.1016/j.ajss.2026.100248

Suhartanto, D., Fadhlurrahmah, S. N. A., & Chaerunisa, K. A. (2026). Faith-aligned experience in urban parks: Linking satisfaction to loyalty and responsibility among Muslim visitors. *Journal of Islamic Marketing*, *17*(7), 2469–2485. https://doi.org/10.1108/JIMA-06-2025-0357

Torrance, A. W. (2026). OSCULATION REGULATION - THE LAW OF THE KISS. *Evolution and Human Behavior*, *47*(5), 106917. https://doi.org/10.1016/j.evolhumbehav.2026.106917

Truc, L. Q. (2026). Forgive me, Baby!: Applied theatre, spirituality, and teacher identity work in EFL teaching. *Social Sciences & Humanities Open*, *14*, 103256. https://doi.org/10.1016/j.ssaho.2026.103256

Turdumambetov, B. (2026). Tablighi travel and the limits of tourism. *Annals of Tourism Research*, *118*, 104175. https://doi.org/10.1016/j.annals.2026.104175

Zhang, H., Qian, J., & Kong, L. (2026). Spiritual gentrification amid the rise of platform urbanism: "Wanghong temples" and emerging Buddhist cultural economies in Tianzhu Road, Hangzhou, China. *Geoforum*, *171*, 104593. https://doi.org/10.1016/j.geoforum.2026.104593

Zhang, H., Wen, J., Huang, K., Kozak, M., & Fan, Y. (2026). The "original face": Visitors' experience in Buddhist pilgrimage tourism through the lens of Zen thought. *Journal of Hospitality and Tourism Management*, *66*, 101387. https://doi.org/10.1016/j.jhtm.2025.101387

Zhu, M., Tu, X., Gedecho, E. K., & Kim, S. (Sam). (2026). Effects of a historical and cultural icon on tourism destinations: A study of Confucius's birthplace in China. *Journal of Destination Marketing & Management*, *42*, 101141. https://doi.org/10.1016/j.jdmm.2026.101141

Copyright Holder :
© Name Author et al. (2026).

First Publication Right :
© Journal of Midwifery History and Philosophy

This article is under:

