

Food Related Taboos Observed During Pregnancy in Malawi

Cecilia Promise Maliwichi-Nyirenda¹ and Lucy Lynn Maliwichi²

¹*Indigenous Knowledge Centre, Blantyre, Malawi*

²*Department of Consumer Science, University of Venda, Thohoyandou, South Africa*

E-mail: ¹<nyirendacecilia@yahoo.co.uk>, ²<Maliwichi@univen.ac.za>

KEYWORDS Food. Taboos. Pregnancy. Eating Habits. Traditional Beliefs

ABSTRACT Malawi's maternal mortality rate is among the worst (675 maternal deaths per 100,000 live births). Pregnancy-related cases are key causes, hence the need to safeguard pregnancy. Traditional beliefs and ignorance are also believed to be some of the contributing factors. The study investigated food-related taboos observed during pregnancy. Qualitative research methods were used. These were: questionnaire interviews, focus group discussions, key informants and participant observations were used in data collection. Forty-six taboos were classified and documented into dietary, behavioural, sexual and cultural categories. Most of the participants had a low literacy level; therefore the taboos were meaningful to them as they were generation-generation knowledge. Although not all the taboos were harmful but there were some that were found to be detrimental to health, particularly dietary taboos, which prevent pregnant women from eating nutritious foods and endanger human life. The biggest challenge was that most of the taboos lacked scientific justifications. Nutritional education and awareness raising programmes should be instituted to discourage people from observing the detrimental taboos. Useful taboos should be encouraged. More research should be done to ascertain the meaning and the origin of the food taboos.

INTRODUCTION

In 2009, Malawi launched an African Union initiative known as Campaign for Accelerated Reduction on Maternal Mortality (CARMMA). The aim of the initiative is to reduce maternal mortality, which is one of the worst in the world at 675 maternal deaths per 100,000 live births (Malawi National Statistical Office 2010). Pregnancy-related complications are among the main causes of maternal mortality. Nation (2007) stated that traditional beliefs and ignorance are also believed to be some of the contributing factors towards the high maternal mortality rates. Consequently, the government is tirelessly trying to find strategies of improving the health status of women through the Safe Motherhood Programme (SMP) that is aimed at reducing maternal mortality through, among other things, creating awareness, at community level, of the risks of pregnancy and the need for utilizing health services. The programme was launched in 1987 in Nairobi, Kenya (Moyo 2007).

Just like most African countries, in Malawi people observe various rites and traditions. These mark different critical stages of life such as birth, marriage and death (Munthali and Zulu 2007). Although some rites and traditions are

beneficial, others are detrimental. The beneficial ones include teaching adolescents to respect adults, discouraging girls from engaging in sex (to avoid getting pregnant) and teaching them cooking and hygiene. United Nations Fund for Population Activities (UNFPA) cites that detrimental rituals include girls having sex with a stranger in-order to learn how to maintain sexual affairs (UNFPA 2007). In other areas of Malawi, especially Lower Shire, there is widespread belief that a widow needs to have sex with a stranger in order to please the spirits of her deceased husband (Munthali and Zulu 2007). With respect to pregnancy, most of the rituals that are observed, aim at preventing miscarriage. These include avoidance of infidelity and abstinence when a woman is at least seven months pregnant (Malawi Human Rights Commission 2006).

The traditions and rites influence the women's ability to seek modern maternal healthcare delivery services. Despite traditional beliefs being upheld in societies, there is scant information on the rituals that are observed during pregnancy. The present study investigated food-related taboos in view of the fact that such taboos influence frequency, amount and quality of nutrients consumed by mothers and children (Perez 2013).

METHODOLOGY

A qualitative study was conducted in which various tools were used. These included ques-

Address for correspondence:

Cecilia Promise Maliwichi-Nyirenda,
P.O. Box 3168,
Blantyre, Malawi.

tionnaire interviews, focus group discussions, key informants and participant observations were employed in data collection.

Study Area

The study took place in Mulanje District, south of Malawi (Fig. 1a). The district borders Mozambique and contains Mount Mulanje (also known as Mulanje Massif), the highest mountain in south-central Africa. The district is dominated by tea estates, one of the major foreign exchange earners for Malawi, after tobacco. Apart from working in tea and coffee estates, people of Mulanje earn their living from subsistence farming.

The study was undertaken in Traditional Authorities (T.A.) Nkanda and Mabuka (Figs. 1b and 1c). The T.A.s were selected because in the former, the district hospital is far away while in the latter, it is closer. Chipoka, Kanyandula, Kapesi, Likhomo, Mphuchila, Ngwezu and Sazola villages of T.A. Mabuka were visited. John, Kalima, Mbewa, Mwanakhu, Mwanero, Nakho-nyo and Nankwakwala villages situated in T.A. Nkanda were visited.

Sampling Procedure and Data Collection

Data were collected through the following methods:

Focus Group Discussion

Focus group discussions were done to identify issues of concern to the general public, Non-Governmental Organisations and policy makers. Focus group discussions were conducted among local communities, Traditional Medical Practitioners, Traditional Birth Attendants, and Maternal and Child Health staff of Mulanje District Hospital, Mulanje Mission Hospital, and Lauderdale, Sayama and Chambe health centres. People with experience in maternal and child health care participated in the focus group discussions. Because there were few people in some categories, single focus group discussions could not be done. Hence the researchers had combined focus group discussions. Consequently, four focus group discussions were done in total. Pregnant women were excluded from these focus group discussions. Instead, they were

considered as key informants because they were central to the focus of the study.

Questionnaire Interviews

All Traditional Birth Attendants and Traditional Medical Practitioners in the study sites were purposively sampled. For the general population, opportunistic sampling was employed because of its quickness. Every adult identified during the questionnaire administration period was interviewed. A total of two hundred and two respondents (142 females and 60 males) were interviewed.

Key Informants

All pregnant women participated in in-depth interviews. In addition, all people and institutions known to work in maternal and child health programmes were purposively targeted. A total of 12 key informants were consulted.

Data Analysis

Data from focus group discussions, key informants and participant observation was analysed manually by extracting themes and attaching them to similar information obtained from questionnaire interviews. Information from questionnaires was analysed using Statistical Package for Social Scientists (SPSS) computer programme. The data was coded, entered into SPSS and analysed using descriptive statistics to calculate frequencies (numbers and percentages) and make cross tabulations. The output was imported into Microsoft Excel computer software package to create charts.

Ethics and Participants Consent

Mulanje District Commissioner gave permission for the study to be undertaken in the district. Permission to interview hospital staff was obtained from the District Health Officer. At village level, the Traditional Authorities, Group Village Headmen and Village Headmen authorised the study. The participants gave verbal consent prior to the interviews.

RESULTS

In order for a pregnant woman to deliver successfully, people believed that she should observe some cultural formalities throughout her

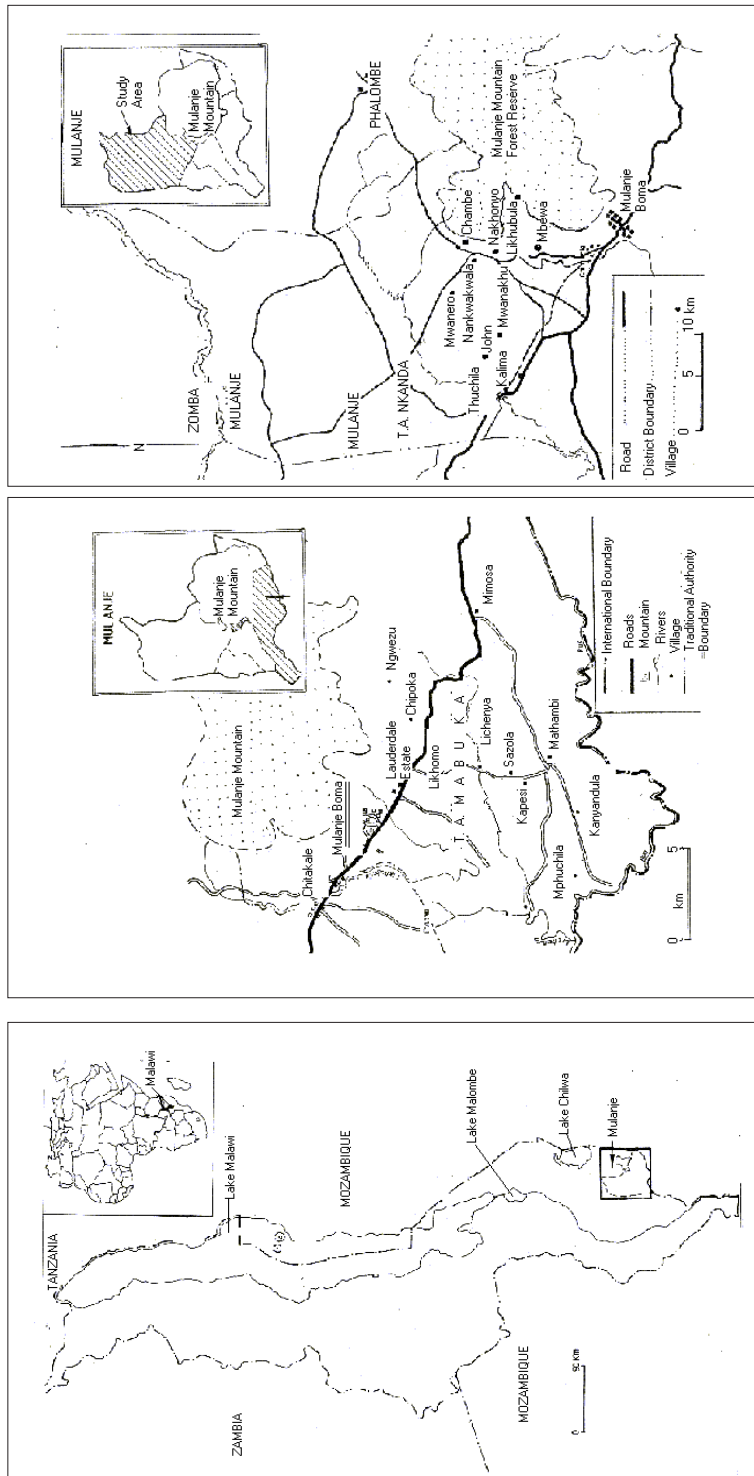


Fig. 1. Map of study area showing location of Mulanje district in Malawi (a), Traditional Authority Mabuka (b) and Traditional Authority Nkanda (c).

pregnancy period. These formalities comprised what communities perceived to be taboos. Forty-six taboos, classified into behavioural, cultural, dietary and sexual categories were documented. Of the taboos that were documented, the most common/popular were in two categories; eating cooked food sold in the market and eating food prepared by unknown people (mentioned by 16 percent and 10 percent of the respondents respectively). The other taboos that

were mentioned by reasonable number of people were eating other peoples' food and eating eggs (mentioned by 8 percent and 4 percent of the respondents respectively) (Table 1).

Respondents mentioned that the taboos are associated with consequences if pregnant women do not observe them. The consequences were either on the pregnant women or the unborn child. 21 consequences affecting pregnant women were recorded while 10 consequences

Table 1: Food-related taboos observed by pregnant women

Taboo	Consequence	Frequency (N = 110)	
		Number of respondents	% of respondents
Eating cooked food sold on the market	Miscarry (for example, following opening of the bowels), bewitched particularly due to salt	18	15.9
Eating food prepared by unknown people	Stomach pains; miscarriage; bewitchment	11	9.8
Eating other people's food	Miscarry or giving birth to dead baby, bewitchment	9	8.0
Eating eggs	Stomach pains; baby becomes bald headed; baby does things similar to eggs	5	4.4
Eating bush meat	Difficulties in giving birth; miscarriage	2	1.8
Eating food with chillies	Baby has outgrowths / wounds	2	1.8
Eating hot food	Miscarriage; baby is scorched	2	1.8
Eating worthless animals e.g. baboons and monkeys	Baby's behaviour takes after the animal	2	1.8
Drinking water with other people's cup (when labour starts)	Miscarriage	1	0.9
Eating food containing baking soda	Pregnant 'ona's stomach becomes dysfunctional	1	0.9
Eating sugarcane	Woman shivers during and soon after labour	1	0.9
Eating flying ants	Woman shivers during and soon after labour	1	0.9
Eating cooked food which is not fresh	Miscarriage	1	0.9
Eating black ants	Baby becomes black in complexion	1	0.9
Eating food prepared during unveiling of tombstone ceremony	Miscarriage	1	0.9
Eating food prepared by a married person	Miscarriage	1	0.9
Eating food prepared by people who have never given birth before	Can get diseases	1	0.9
Eating food or drinking water cooked or drawn by a pregnant woman or her mother	Miscarriage or deliver a dead baby	1	0.9
Eating maize meal porridge which other people have already started eating	Miscarriage	1	0.9
Eating meat from animals with coat	Baby takes time to get out of uterus	1	0.9
Eating unbalanced meal	Discomfort in the stomach	1	0.9
Eating intestines of any animal	Baby is interwoven in mother's intestines	1	0.9
Eating food whose salt was put by someone	Brings diseases	1	0.9
Eating roast fish	Baby develops rash or sores in the face	1	0.9

affected unborn children. The most commonly mentioned consequence affecting pregnant women was miscarriage (mentioned 10 times). In case of the unborn child, the frequently mentioned consequence was to do with skin (skin rash, scorching or changing complexion). This was mentioned four times.

Interestingly, there was a peculiar consequence that was mentioned with respect to the unborn child. This was in terms of the child's personality taking after the animal which the pregnant woman ate (mentioned three times) for example, a baby becoming black in complexion because the mother ate black ants.

DISCUSSION

The study found that food-related beliefs and taboos are common in the study area. Taboos are not uncommon in most African countries. For instance, Cunningham (2001) states that in Durban, South Africa, traditional medicines such as *Alepidia amatymbica* and *Siphonochilus aethiopicus* decline sharply in spring and summer because there is a taboo against collecting them during the growing season. Once the taboo is broken, it is believed that lightning strikes the household. In Angola, post war trauma in children is treated by indigenous psychotherapeutic practice that is associated with such taboos as non-interaction with family friends before ritual cleansing and seclusion from other village members until the ritual is performed (Green and Honwana 1999). Food-related taboos contribute to depletion of vital nutrients in the body (Oni and Tukur 2012; Parmar et al. 2013).

In a village set up in Malawi, the woman's gestation period does not render her free due to the diversity of the taboos that need to be respected. This study has revealed that the frequently observed taboos ban pregnant women from eating food sold in markets and food prepared by unknown people. These taboos might have been created to manage hygiene, to ensure that pregnant women eat nutritional balanced meals, eat freshly cooked food to avoid viral stomach infections that lead to diarrhoea. Avoidance of eating too much fish could be to lessen intake of mercury. Control of high salt intake could be to prevent the woman from suffering from high blood pressure.

The study further showed that there were no differences in opinion between the tradition-

al birth attendants, traditional medical practitioners and pregnant women. This could be due to the fact that cultural norms are deep rooted in the villages of Malawi. The norms are passed from one generation to the other through properly organised structures such as initiation ceremonies and traditional counselling services that are provided to pregnant women.

Except for eating eggs, most of the mentioned taboos relate to miscarriage. Having so many food restrictions may disadvantage the pregnant woman and forthcoming baby as they may be denied of essential food nutrients. In modern Malawi, people realise the importance of pregnant women being given essential foods. For example, in a study by Malawi Human Rights Commission (2006), respondents expressed the need for the food-related taboos to be abolished because they prevent the pregnant women from getting nutritious foods (Malawi Human Rights Commission 2006).

Most taboos have a cultural origin and meaning that cannot be scientifically corroborated. For instance, banning a pregnant woman from eating animals considered to be unimportant, like baboons and monkeys, with the fear that the baby's behaviour will be similar to such animals is difficult to explain. In addition, there are other taboos whose effects are doubtful. For example, delay in birth if a pregnant woman eats animals with fur. Some of the taboos indicate ignorance among communities. For instance, baby becoming scorched after the mother ate hot food. This shows that people's perception is that the baby is in the stomach. They are not aware that the baby is in the uterus. Similar doubts were observed in Malawi by the Human Rights Commission study where most respondents stated that some of the beliefs did not serve any particular function (Malawi Human Rights Commission 2006).

All in all, Chirombo et al. (1998) confirm that in Malawi and Africa, various taboos exist especially with respect to pregnancy. In addition, having numerous taboos makes it difficult for the pregnant women (most of whom are illiterate) to remember such taboos. As such, she is under panic to ensure she does not break any of the taboos.

During pregnancy a woman's nutritional needs become greater than at any other times in her life. As the woman nourishes herself she also nourishes the growing foetus. A pregnant

woman's food intake increases to meet her nutrient needs and the needs of the growing foetus. The foetus takes most of the nutrients it requires from the mother irrespective of whether the mother has nutrient deficiencies or not. Low birth weight of babies often results from under-nutrition of the mother during pregnancy (Latham 1997).

CONCLUSION

This study has shown that despite most people in the study area having limited or no formal education, they know several pregnancy-related taboos. The taboos have most impact on the mother with the majority leading to miscarriage. Since miscarriage terminates the baby's life, many people are bound to observe taboos that would enable them prevent miscarriages. Due to high frequency of respondents that mentioning this consequence (miscarriage), it implies many women end up not eating related food stuffs.

RECOMMENDATIONS

There is need for the Malawi Ministry of Health and Population to come up with strategies that will ensure that nutritional education and awareness raising programmes should encourage taboos that do not compromise people's health. Awareness raising campaigns should be done on taboos that are unfounded in order to discourage people from observing them. To ensure that people accept the advice easily, traditional structures (such as initiation ceremonies) and chiefs could be used.

More studies are also needed to verify if the documented taboos result in the corresponding consequences to enable communities make informed decisions.

ACKNOWLEDGEMENTS

Authors are grateful to UNESCO (People and Plants programme) for the financial contribution provided. We are also thankful to all the respon-

dents that provided the invaluable information.

REFERENCES

- Chirombo A, Gama J, Hara M, Nyondo L, Kandikole, M. 1998. Early Pregnancies: The Role of University Students on the Welfare of Rural Children. *A Paper Presented at a Workshop Held at Natural Resources College*, Natural Resources College, Lilongwe, Malawi.
- Cunningham AB 2001. People, wild plant use and conservation. *Journal of Ethnobiology*, 17: 215-233.
- Green EC, Howana A 1999. Indigenous healing of war: Affected children in Africa. *Indigenous Knowledge Notes*, 10: 98-101.
- Latham CL 1997. *Human Nutrition in the Developing World*. Rome: FAO.
- Malawi Human Rights Commission 2006. Cultural Practices and Their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi. From <http://www.malawihumanrightscmission.org/docs/cultural_practices_report.pdf> (Retrieved on 24 November 2009).
- Malawi National Statistical Office 2010. The 2010 Malawi Demographic and Health Survey. From <<http://www.measuredhs.com/pubs/pdf/FR247/FR247.pdf>> (Retrieved on 13 October 2014).
- Moyo NT 2007. First stop on the ICM Safer Motherhood World Tour 2007, Lilongwe, Malawi: Innovative event which puts midwives at the heart of action to make childbirth safer in Malawi. *International Midwifery*, 202: 23-26.
- Munthali AC, Zulu EM 2007. The timing and role of initiation rites in preparing young people for adolescence and responsible sexual and reproductive behaviour in Malawi. *Afr J Reprod Health*, 11(3): 150-167.
- National Statistical Office (NSO) and ICF Macro 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.
- Oni O A, Tukur J 2012. Identifying pregnant women who would adhere to food taboos in a rural community: A community-based study. *African Journal of Reproductive Health*, 16(3): 67-75.
- Online <<http://www.nationmw.net>> (Retrieved on 10 October 2007).
- Online <<http://www.unfpa.org/fistula/docs/malawi.pdf>> (Retrieved on 24 November 2009).
- Parmal A, Khanpara H, Kartha G 2013. A study on taboos and misconceptions associated with pregnancy among rural women of Surendranagar district. *Healthline*, 4: 2.
- Perez GM, Garcia AP 2013. Nutritional taboos among the Fullas in Upper River Region, The Gambia. *Journal of Anthropology*, Article ID 873612.

Paper received for publication on August 2013
Paper accepted for publication on January 2016