

Socio-Cultural Practices Affecting Dietary Intake Among Pregnant Women In Migratory Communities. A Case of Maasai Community of Narok County, Kenya.

CHEPKORIR VIOLAH

Abstract

Migratory communities are known for maintaining their traditional cultural beliefs and practices. Some of the notable cultures involving the control of dieting of pregnant mothers are believed to have benefits to the mothers. However, dietary restrictions not backed by science predispose mothers and child to nutritional deficiencies which are likely to be associated with the high statistics of maternal deaths in sub-Saharan Africa. Little is documented on the social-cultural practices affecting dietary intake of pregnant mothers from the Maasai Community in Kenya. This study sought to assess the socio-cultural practices affecting dietary intake of pregnant women of Maasai community in Narok County. The study was conducted in Ewaso Ng'iro Health centre, at Maji-Moto Naroosura ward in Narok County, Kenya. The study participants were women who tested positive for pregnancy and documented in maternal child health card, and were enrolled at antenatal clinic at Ewaso Ng'iro Health centre. The study included 373 pregnant women aged 15-49 years who actively attended their antenatal clinic and were willing to voluntarily participate in the study. The findings revealed that: Restriction of proteins as a socio-cultural practice might have affected dietary intake of proteins, which is a major source of Iron. This practice may have contributed to IDA among pregnant women in the migratory community. Another socio-cultural practice that might have contributed to IDA was reduction of food intake among pregnant women. This affected the overall nutrient intake causing inadequate Iron intake a major micronutrient in prevention of IDA. Induced vomiting was another socio-cultural practice, which was highly practiced among pregnant women in the migratory community. These subjected pregnant women to lose most of the macronutrients and micronutrients causing ID. All these were done with the perception of avoiding the growth of huge babies during delivery.

Keywords: Dietary Intake, Socio-Cultural Practices, Pregnant, Migratory Communities

Date of Submission: 26-07-2021

Date of acceptance: 11-08-2021

I. Introduction

Nutrition of a mother before, during and after delivery is a critical component to the health of the mother and the child. Studies such as Getachew, Yewhalaw, Tafess, Getachew, & Zeynudin, (2012) maternal nutrition, maternal age (less than 18 years), birth spacing, inadequate prenatal care, lifestyle behaviors and poverty to pregnancy outcomes. Currently, pregnant women account for 24.8% of 3.7 billion people of the most vulnerable population (Kaur, 2016).

The highest prevalence of nutritional deficiency among pregnant mothers exists in the developing world which is thought to be associated with socio-economic factors, inadequate food intake and cultural taboos that hinder intake of certain foods known to be good sources of nutrition during pregnancy. At the same time, there are high number of infections, multiple pregnancies and low contraceptive prevalence use in these less developed countries (Okube, Mirie, Odhiambo, Sabina, & Habtu, 2016). Almost 90% of all global maternal deaths occur in sub-Saharan Africa (Van Den Broek & Falconer, 2011). Moreover, in Sub-Saharan Africa, nutritional deficiencies are the most common causes of anaemia among pregnant women (VanderJagt et al., 2007). A study by Addis et al. reported that 17% of Ethiopian women of reproductive age were anemic and out of which, 22% of those women were found to be pregnant (Addis Alene & Mohamed Dohe, 2014a). The cultural beliefs and practices unique to sub-Saharan African countries are therefore of interest to the study of maternal health and nutrition.

Narok County in Kenya is mostly inhabited by the Maasai community who occupy both Arid and Semi-arid land. The Maasai community is known for maintenance of their culture and traditional practices in their family set ups. Most of the Maasai people practice semi-nomadic kind of life whereby, the movement of livestock is based on seasonal rotation to greener pastures (Lennox, Petrucka, & Bassendowski, 2017). In addition, Livestock such as cattle, goats and sheep are the primary source of income to them and therefore may not be utilized for food even when they are the rich sources of iron especially for pregnant mothers. The cultural practices such as pregnant mothers being not allowed to consume, milk, eggs and green leafy vegetables

because it is believed that the baby will grow huge and delivery will be a problem worsen the access of iron in food believed to be good sources of iron (Lennox et al., 2017).

Traditionally, during pregnancy Maasai women consumed a modified diet that included restricting caloric consumption during and after 6 months of pregnancy (Brady, Suksiri, Tan, Dodds, & Aine, 2008). The dietary restrictions in the community is believed to guarantee smaller babies, thereby facilitating safe delivery and limiting medical interventions during childbirth (Brady et al., 2008). Moreover, the community elders and the TBAs often enforce this practice in the first pregnancy, and women opt to follow this pattern in subsequent pregnancies. According to a study that was conducted in rural Gambia, a study site with similar social demographic characteristics with the study area, it was noted that the Maasai pregnant women's dietary patterns on average, had a lower intake of carbohydrates, proteins, and fats per day than the recommended daily intakes (Lowe, Chen, & Huang, 2016).

Problem Statement

Narok County in Kenya is an area mostly inhabited by the Maasai community, who keep migrating from time to time in search of greener pastures for their livestock. Thus, as the husbands (household heads) migrate, women are left alone to take care of their families in terms of looking for food and doing other extra expending activities like fetching water and building houses. With this, most pregnant women are exposed to nutritional deficiency, and heavy house hold chores as they cannot afford to access nutritious foods. Furthermore, the African culture restricts pregnant mothers from undertaking certain foods due to risks associated with such in the health of the mother and the child.

In addition, early marriages are still common in Narok County, and often this is associated with early child bearing, thus young pregnant women may not build enough nutritional stores for pregnancy, hence predisposing them to low stature and malnutrition (Mutugi, 2012). Consequently, the use of herbal remedies is a common practice among pregnant mothers in Narok County, which may cause drug nutrient interaction that can reduce iron bioavailability and its overall absorption resulting to IDA (Lennox et al., 2017). These cultural practices predispose pregnant mothers to risk of malnutrition thus endangering the life of the baby and the unborn child. To this end, little is documented on the social-cultural practices affecting dietary intake of pregnant mothers from the Maasai Community in Kenya.

Objective

To assess the socio-cultural practices affecting dietary intake of pregnant women of Maasai community in Narok County.

II. Methodology

The study was conducted in Ewaso Ng'iro Health centre, at Maji-Moto Naroosura ward in Narok County, Kenya. The study participants were women who tested positive for pregnancy and documented in maternal child health card, and were enrolled at antenatal clinic at Ewaso Ng'iro Health centre. The study included 373 pregnant women aged 15-49 years who actively attended their antenatal clinic and were willing to voluntarily participate in the study.

III. Findings

Social Economic Characteristics of Pregnant Women of maasai Community of Narok County, Kenya.

Social Economic Characteristics of Pregnant Women of maasai Community of Narok County

Characteristic	Frequency (n)	Percentage (%)
Age (mean, SD) (24.9 ± 6.5)		
Age (Years)		
<18	39	10.5
18-24	119	31.9
25-33	144	38.6
34-44	66	17.7
45-49	5	1.3
Marital status		
Married-monogamous	127	34.1
Married-polygamous	174	46.7
Separated Divorced	9	2.4
Widow	19	5.1

Single	44	11.8
Education Level		
No formal education	93	24.9
Primary	121	32.4
Secondary	91	24.4
Post-secondary	68	18.2
Occupation		
Salaried employee	29	7.8
Business	87	23.3
Housewife	169	45.3
Casual laborer	51	13.7
Students	37	9.9

Of the 373 study participants interviewed the mean age was 24.9 (SD± 6.5), whereby the majority, 144 (38.6%) were 25-33 years, followed by 119 (31.9%) aged between 18-24 years with a small number aged 45-49 years 5 (1.3%). The study also revealed that, most of the families were polygamous, with a total number of 174 (46.7%) followed by monogamous families 127 (34.1). There were also a number of single families 44 (11.8%). From the study, the level of education was low, in that majority of the pregnant women 121 (32.4%) had primary education, followed by informal education 93 (24.9%). Those who had secondary education were 91 (24.4%) and only a few of them had post-secondary education 68 (18.2%).

Socio- Cultural Practices affecting Dietary intake of Pregnant Women in Migratory Community

Socio-Cultural Practices affecting Dietary Intake of Pregnant Women in Migratory Community

Practice*(n=373)	Yes n (%)	No n (%)	Reason associated with Practice**
Reduction of food intake during pregnancy	352 (94.4)	21 (5.6)	To prevent the growth of a huge baby
Restriction of proteins (meat, eggs, milk)	373 (100%)	0 (0)	To prevent the growth of a huge baby
Eating last after meals (After all members of the family have eaten)	310 (83.1)	63 (16.9)	To prevent Pregnant women from consuming a lot of food
Induced vomiting after meals	278 (74.5)	95 (25.5)	To purify the mother's blood stream, reduce the size of the baby

*Cultural practices of the migratory community influencing dietary intake

**Reason associated with the practice

From the findings the study indicated that the majority of the pregnant women 352 (94.4%) do reduce the amount of food consumption during pregnancy; while only a few of them 21 (5.6%) did not reduce. This was actually associated with reducing the size of the baby in order to ease delivery. In addition, the findings revealed that during pregnancy, all pregnant women 373 (100%) consumed a modified diet, where proteins such as meat, milk and eggs were strictly restricted. This was mainly to prevent the growth of a huge baby. Further, in line with the findings of the study, most pregnant women (83.1%) reported to be eating last during meal times, after everyone else had eaten, while only a few (16.9%) did not eat last during meals. This was because it was believed that pregnant women were not supposed to eat a lot of food. Therefore, they were to consume the little food left and if there was none, they were supposed to wait for the next meal.

IV. Discussion of Findings

It was evidenced that eating habits of the pregnant women were mostly dictated by the cultural practices and beliefs of the migratory community. Some of the socio-cultural practices that influenced the dietary intakes of the pregnant were as follows;

Practice 1: Reduction of food intake

The study indicated that the majority of the pregnant women 352 (94.4%) do reduce the amount of food they take during pregnancy; while only a few of them 21 (5.6%) did not reduce. This practice, reveals the belief in the local community, that a pregnant woman's food intake must be decreased in order to prevent the growth of a huge baby that may lead to pregnant women undergoing caesarean section or difficult delivery at home. This belief seemed to relate to a number of factors such as risk of death due to a large infant, concern for

lack of specialized care if the baby is not born naturally, and concern over health of a big infant. This finding was in agreement with a study conducted by (Lennox et al., 2017).

Practice 2: Restriction of proteins (Meat, eggs and milk)

The findings revealed that during pregnancy, all pregnant women 373 (100%) do take modified diet. The intention to eat a modified diet is normally based on advice by the mother in laws and traditional birth attendants who emphasizes on restricting proteins such as meat, milk and eggs, after the sixth month of pregnancy in order to facilitate an easier delivery as well as a healthier baby (Brady et al., 2008). The main reason that was given was that, majority of the pregnant women travel long distances to health facilities, and therefore they value the tradition of giving birth at home under the help and supervision of a traditional birth attendant.

Practice 3: Eating last after meals (after all members of the family have eaten)

Most pregnant women (83.1%) reported to be eating last during meal times, while only a few (16.9%) did not eat last during meals. The reason given behind this practice was that, it was not mandatory for the pregnant women to eat, because the baby could grow big. Therefore, to avoid the growth of a huge baby, pregnant woman was supposed to eat less food, from the remains of what the family members had eaten. If no food remains, the pregnant woman was supposed to wait until the next mealtime to see if she could get something to eat. The mother in-laws were supposed to supervise meals in order to ensure the pregnant women ate last, and sometimes she could ensure that nothing remained for the pregnant woman

Practice 4: Induced vomiting

It was found out that, during pregnancy, majority of the Maasai pregnant women 278 (74.5%) reported the diet during this stage of pregnancy excludes rich foods, such as fatty meats or milk, and vomiting was often induced with the use of bitter roots and herbs as a way of purifying the mother's blood stream to keep the baby healthy. Sometimes the pregnant women were subjected to taking plenty of warm water, in order to induce vomiting. These practices were widely enhanced mainly to protect the health of the mother and child, and ensuring successful pregnancy outcome. It was found out that, during pregnancy, majority of the Maasai pregnant women 278 (74.5%) reported that the diet during this stage of pregnancy excluded rich foods, such as fatty meats or milk.

V. Conclusion

Restriction of proteins as a socio-cultural practice might have affected dietary intake of proteins, which is a major source of Iron. This practice may have contributed to IDA among pregnant women in the migratory community. Another socio-cultural practice that might have contributed to IDA was reduction of food intake among pregnant women. This affected the overall nutrient intake causing inadequate Iron intake a major micronutrient in prevention of IDA. Induced vomiting was another socio-cultural practice, which was highly practiced among pregnant women in the migratory community. These subjected pregnant women to lose most of the macronutrients and micronutrients causing ID. All these were done with the perception of avoiding the growth of huge babies during delivery. The County health department therefore, should strengthen the policies for combating micronutrient deficiencies through integration of programmes and services at the community levels.

References

- [1]. Addis Alene, K., & Mohamed Dohe, A. (2014a). Prevalence of Anemia and Associated Factors among Pregnant Women in an Urban Area of Eastern Ethiopia. *Anemia*, 2014(May 2013), 561567. <https://doi.org/10.1155/2014/561567>
- [2]. Brady, R., Suksiri, S., Tan, S., Dodds, J., & Aine, D. (2008). Current Health and Environmental status of the Maasai People in Sub-Saharan Africa. *California Polytechnic Honors Undergraduate Research Journal*, 1(1), 17–32.
- [3]. Getachew, M., Yewhalaw, D., Tafess, K., Getachew, Y., & Zeynudin, A. (2012). Anaemia and associated risk factors among pregnant women in Gilgel Gibe dam area, Southwest Ethiopia. *Parasites & Vectors*, 5(1), 296. <https://doi.org/10.1186/1756-3305-5-296>
- [4]. Lennox, J., Petrucka, P., & Bassendowski, S. (2017). Eating practices during pregnancy: perceptions of select Maasai women in Northern Tanzania. *Global Health Research and Policy*, 2(1), 9. <https://doi.org/10.1186/s41256-017-0028-9>
- [5]. Lowe, M., Chen, D., & Huang, S. (2016). Social and Cultural Factors Affecting Maternal Health in Rural Gambia: An Exploratory Qualitative Study, 1–16. <https://doi.org/10.1371/journal.pone.0163653>.
- [6]. Mutugi, M. P. (2012). Prevalence of low birth weight deliveries and associated factors in Narok district hospital, Kenya.
- [7]. Okube, O. T., Mirie, W., Odhiambo, E., Sabina, W., & Habtu, M. (2016). Prevalence and Factors Associated with Anaemia among Pregnant Women Attending Antenatal Clinic in the Second and Third Trimesters at Pumwani Maternity Hospital, Kenya, (January), 16–27.
- [8]. Van Den Broek, N. R., & Falconer, A. D. (2011). Maternal mortality and Millennium Development Goal 5. *British Medical Bulletin*, 99(1), 25–38. <https://doi.org/10.1093/bmb/ldr033>
- [9]. Vander Jagt, D. J., Brock, H. S., Melah, G. S., El-Nafaty, A. U., Crossey, M. J., & Glew, R. H. (2007). Nutritional factors associated with anaemia in pregnant women in northern Nigeria. *Journal of Health, Population and Nutrition*, 25(1), 75–81.