

Title

The role played by taboos in exposing women to maternal mortality in Binga, Zimbabwe

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Abstract

Taboos are prohibited behaviours that have supernatural explanations, they affect women during pregnancy, childbirth and during the lactation period, resulting in high maternal mortality rates. The objectives of this study were to explore cultural taboos that expose women to maternal mortality and to examine the role of taboos in maternal health care. The study employed a qualitative research approach, making use of focus group discussions, and key informant interviews as data collection methods. Twelve (12) focus group discussions consisting of 6-12 people were conveniently sampled from villages in ward 1 Binga. The study found out that food taboos like prohibited starchy foods, protein meats exposed pregnant women to malnutrition and health complications. Cultural taboos delayed pregnant women from accessing maternal health care. Cultural taboos like bidding farewell to pregnant women and being escorted by pregnant women when leaving their homestead, limited pregnant women's chances of getting transport assistance from neighbours and friends. On the other hand the study found out that taboos had cultural significance in Binga hence why women adhered to them. It can thus be concluded that taboos should be well known beyond the current body of knowledge if maternal mortality rates are to decline in Zimbabwe. They should be critically analysed and unpacked to decipher the content of the knowledge within them from an Afro centric perspective and a conventional point of view. Finally, the study recommends the need for appropriate strategies to disseminate information of taboos that contribute to maternal mortality and reinforcing taboos that preserve our cultural heritage.

Key words

maternal health care, maternal mortality, maternal morbidity, delay, pregnant women, and cultural taboos.

Key dates

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Introduction

Numerous factors contribute to the vulnerability of children, which, in turn, demands protection and care. There is high maternal mortality in most developing countries as compared to the developed world (United Nations Population Fund, 2018). For instance, while maternal mortality in Zimbabwe is 443/100000 in Estonia it is only 9/100000 (World Health Organization, 2018). This disparity has precipitated the need to bring out socio-cultural factors that expose women to maternal mortality and morbidity. A number of maternal health studies have concentrated on the medical causes of maternal mortality with very few studies focusing on socio-cultural factors. This paper brings out the dilemma of choice that pregnant women face in their quest for maternal health services within their families and communities. Faced with a number of maternal health options, women's choices affect the end result of the pregnancy. The paper is arranged into the following sections: the introductory section, which is followed by the background of the study which presents a historical overview of taboos and maternal health. The third section is the methodology section, which is followed by the research findings sections. The paper then presents a conclusion and recommendation section which are drawn from the research findings section.

Background

Globally, maternal mortality is a result of preventable and curable causes which are related to maternal health. Most first world countries have made significant strides in their efforts to address these causes, leading to the reduction of maternal mortality and morbidity. World Health Organisation, (2018) notes that in developing countries most maternal deaths are as a result of poverty; long distance to the nearest health facility; lack of health information; inadequate services and cultural practices which in turn delay women from accessing maternal health care. Studies by Phuong, Tina, Sunny, Lan, Kaosar, Zeba, Bachera, Purnima, (2017) are consistent with such thinking as they highlight five aspects of cultural patterns which have a bearing on maternal health care namely: pregnancy and childbirth; indigenous medical systems; food classifications; child rearing practices and finally patterns of household authority. The afore mentioned aspects make scholars understand disease patterns in communities and provide an insight into people's values, knowledge, and attitudes towards maternal health care. This paper is thus in line with the arguments by Phuong et al, (2017) and Zinyemba, (2020) on food classifications being a determinant factor of maternal mortality with particular attention to the role played by food taboos in exposing pregnant women to maternal mortality and morbidity.

Studies by Wiredu 1996, Sadomba and Wakandigara 2015, define a taboo as a prohibition detesting some extra human who is capable of grueling people with disasters for non-compliance. Such scholars conclude that taboos were not designed to commune facts but were intended to keep safely indigenous knowledge. Cultural taboos are a prevention of

certain acts in society, which detests some extra human who is capable of grueling people with disasters for non-compliance (Phuong et al, 2017). Scholars like Ganle, (2015); Dodzo, Mhloyi, Moyo, Dodzo-Masawi, (2016) further argue that pregnant and lactating women are often limited due to cultural and nutritional taboos; depriving women of essential nutrients during pregnancy. This contradicts the purpose of antenatal care, which is to ensure good health in every expectant mother, so as to enable her to have a normal delivery and a healthy baby. This paper demonstrates the dilemma of choice that pregnant women face in trying to balance between adhering to cultural taboos and maternal health expectations.

Lawrence and Worsley, (2020) note that pregnant women are expected to gain approximately 12, 5 kilograms over the course of their pregnancy. Studies have further revealed that pregnant women with inadequate nutrition have in most instances eaten badly and are poorly grown (Bhatta and Aryal UR 2015). Food taboos do not take into cognisance changes that occur in a pregnant woman's body, which involve a multifaceted interaction of mother and fetal physiological systems (Nejimu, and BizaZepro, 2012).

Studies have further shown that the mother's birth weight influences the infant's birth size, though this is independent of other factors that are known to influence birth weight (Djossinou, Savy, Fanou-Fogny, Landais, Accrombessi, Briand, Yovo, Hounhougan, Gartner, Martin – Prevel, (2020). It can thus be concluded that infant birth weight is an indicator of a successful pregnancy. While on the other hand a low birth weight is as a result of poor pregnancy outcome though there are other factors, like preterm babies are generally smaller than their counterparts born at term (Djossinou, et al, (2020). It can thus be argued that food taboos limit pregnant women's choices of food resulting in women not gaining the required weight.

Studies have further shown that poor nutrition during pregnancy does not only affect the relationship between placental weight and birth weight but continues to have a negative influence into adult life, making individuals prone to a number of diseases (Lawrence and Worsley, 2020). In support, epidemiological studies reveal that individuals who are small at birth have an increased risk of type 2 diabetes and cardiovascular diseases in adulthood (Lawrence and Worsley, 2020). On the other hand, iron is needed for fetal growth, development of the placenta and the increase in the production of maternal red blood cells during pregnancy (Lawrence and Worsley, 2020). This improves the clinical outcome of the pregnancy and the future health of the child.

Studies have also shown that lack of dietary calcium increases the risk of women developing pre-eclampsia and eclampsia during pregnancy. Studies have further shown that pregnant women should increase their protein intake by fifty-one grams per day. It is also recommended that women should have enough intakes of dairy products to increase their calcium intake levels to around 550 mg. Calcium is usually from foods like green vegetables, bread and cereals.

(Lawrence and Worsley, 2020). Magnesium is also vital to pregnant women as it has a significant role in fetal development in the first trimester.

High protein foods like milk, eggs and some meats were reported to be taboo if consumed during pregnancy in most parts of Africa (Uzma, Eram, Tamanna, Humaira, 2016). Eggs for instance, were reported to result in the baby being born with no hair. These food taboos often lead to the deprivation of high protein foods among pregnant women. This study brings out how such food taboos are a cause of concern, as the prohibited sources of food are the main sources of high protein nutrients.

Ganle (2016) notes that eating food that is prohibited was reported in most developing countries to cause pregnancy complications, child death, and misfortune. In some instances, pregnant women were forbidden from eating salty acidic or sour foods as people feared that the infant would be of sour disposition. Ironically, other studies have noted that the consumption of certain foods by pregnant women has been reported to cause the child to like such foods after birth. In some societies eggs were forbidden as they were reported to affect the reproductive functioning of the mother. Such food taboos often lead pregnant women to be deprived of high protein foods such as meat, eggs, fish and milk. Phuong et al, (2017), Dodzo et al, (2016) highlighted the importance of consuming a balanced diet while pregnant which is often affected by a number of factors such as cultural beliefs and social norms. This study fills in the gap of knowledge of how cultural taboos contribute to the delay of women accessing maternal health care.

Studies by Lawrence and Worsley, (2020) have demonstrated the importance of physical exercise during pregnancy. Physical exercise helps to reduce gestational weight gain, and hypertension which is a major cause of maternal mortality and morbidity. Physical exercise also reduces pregnancy complications and improves the health status of pregnant women. Hypertensive disorders during pregnancy exert pressure on pregnant women’s heart and kidneys (Lawrence and Worsley, 2020). It can thus be noted that physical exercise, good nutrition, health information and cultural aspects have a bearing on maternal health. Such aspects make scholars understand disease patterns which affect the maternal health outcome. This paper looks at how cultural taboos and food taboos contribute to maternal mortality and morbidity. The study hence goes further to bring out the role of cultural and food taboos in maternal health. The research further demonstrates how such cultural taboos delay women from accessing maternal health care as demonstrated by Rosenstock, (2005); and Becker (1974) in the four delays model.

Methodology

The research was conducted in Binga district targeting females in the reproductive age group (15–49 years) as they contribute directly to maternal health care. The research

made use of a qualitative research approach making use of key informant interviews and focus group discussions as methods of data collection.

The study was conducted in Binga district ward 1 under chief Sinakatenge and Chief Sinamusanga. The chiefdom of chief Sinakatenge is comprised of 16 villages, namely Sinakatenge, Simolo, Siachiampa 1 and 2, Mukwapata 1 and 2, Sialigabonga 1 and 2, Masili 1 and 2, Chalisenga 1, 2, 3, 4, 5, 6 and 7. The chiefdom of chief Sinamusanga consist of 11 villages namely Siamunza1, 2, 3, 4 and 5, Siamunda 1, 2, 3 and 4, Pandalimu 1 and 2. These two chiefdoms have a total population of 1945 females and 1733 males (Zimstart, 2012). Twelve (12) focus group discussions were conducted with participants who were conveniently sampled from all the 29 villages in ward 1.

Two cohorts were developed for the focus group discussions, dividing the participants by sex (male and female) and age (the young reproductive age group, middle aged and the elderly) to ease the group discussions. A total of 12 focus group discussions were conducted by a male and a female facilitator as shown in table 1 below; six (6) focus group discussions with men as they contribute economically, socially and reproductively to maternal health care. Six (6) focus group discussions were also conducted with women. The group discussion consisted of 6-12 people for ease of group discussions.

Table 1: Distribution of focus group discussions sample

Age	Males	Females
Young age group	2	2
Middle aged group	2	2
Elderly group	2	2

Purposive sampling technique was used to sample 18 key informants that is 3 Traditional birth attendants, 3 Spiritual birth attendants, 3 Nurses, 3 Village health workers, 3 Chiefs and village heads and 3 community elders.

Data was data was imported into NVivo software which organized the data into nodes. The NVivo coding tools assigned codes to the data and the visualization tools then created patterns and relationships in the data. Finally, the NVivo analysis tools brought out themes and drew conclusions from the data.

Ethical clearance to conduct the study was acquired from the District Administrators office and from chief Sinakatenge and Chief Sinamusanga. Participants filled in a detailed consent form, which explained to the respondent the objectives, risks and benefits of the study. Confidentiality, anonymity and voluntary participation was adhered to during the entire data collection, analysis and writing process.

Taboos that expose women to maternal mortality

The main theme that came out of the study were that food taboos were observed during pregnancy. Tonga women adhere to a number of food taboos during pregnancy like dietary meat taboos and dietary starchy foods taboo. The study found out that a lot of precautionary measures were put in place to ensure that pregnant women comply with food taboos during pregnancy.

The study found out that pregnant women adhered to dietary food taboos that limit their carbohydrates and protein intake during pregnancy. On the contrary the key informants (village health workers) reported that such food deficiencies increase pregnant women's risk to maternal mortality and morbidity. The study further revealed that nonadherence to dietary food taboos, resulted in supernatural punishment. Hence most female respondents reported a change in their diet during pregnancy. Such results were reaffirmed by the key informants (community elders) who further indicated that all women adhered to food taboos regardless of their level of education. One young male respondent (James pseudo name) from the focus group discussions highlighted that:

The Tonga culture is strongly embedded in its values and ethics and strong social systems are in place to ensure adherence of food taboos.

Most of the respondents reported to change their dietary meat taboos; they did not consume animal products like eland, zebra, elephant, bush pig, tortoise, hippopotamus and fish. Failure to adhere to the dietary meat taboos resulted in supernatural punishment. For instance, consuming tortoise meat was reported by the traditional birth attendants to result in the unborn child being slow in all activities, be it schoolwork or household chores. Consuming porcupine resulted in the birth of children with pride, which is an attribute that is not expected in the Tonga culture. Fish was reported to cause skin diseases while some game meats were reported to cause poor growth to the neonate. An elderly female respondent from the focus group discussions (Revai) had this to say:

...my sister ate tortoise meat while pregnant and the child is slow in physical development; he behaves and looks like a five-year-old when he is ten years old.

When probed further, to check if the respondents were aware of the consequences of not consuming non protein foods during pregnancy; some of the respondents reported ignorance on the negative effects of dietary meat taboos on pregnancy, hence the reason why they religiously adhered to the food taboos. On the contrary the key informants (nurses) noted that the prohibited meats were the main sources of protein in Binga, resulting in pregnant women being deprived of important nutrients during pregnancy. One respondent from the focus group discussions of middle-aged women (Jane pseudo name) expressly reported that;

On my fourth pregnancy I never ate meat. The meat that was available at home was prohibited...

The study found out that most women did not consume starchy foods during their third trimester of pregnancy. The foods most prohibited were from heavy grains like maize, sorghum and millet. The key informants (nurses) at the clinic reported that adhering to this taboo had negative effects on the pregnancy as starch was highly recommended for pregnant women. The study further noted that starchy foods contributed to pregnant women gaining weight and in turn delivering a healthy baby. They further noted that starchy foods prevented constipation amongst pregnant women. One key informant (Traditional birth attendant) reported that:

...foods high in carbohydrates were not to be consumed as pregnant women would push her bowels instead of the child during delivery.

The research also brought out another major theme of cultural taboos that were followed by Tonga women during pregnancy. The research noted that cultural taboos delayed pregnant women from accessing maternal health services at the clinic. There were a number of cultural taboos like bidding fare well to pregnant women, escorting visitor's taboo, putting hands on the back taboo and digging the "musikka" tree taboo.

Pregnant women were not allowed to bid farewell to visitors. It was reported that if you bid farewell to a pregnant woman, she was more likely to have birth complications. The consequences were reported to be more gruesome if the pregnant woman answered back. When probed on the consequences of not adhering to this taboo the focus group discussions retaliated that this taboo resulted in prolonged labour, resulting in the death of both the mother and child. The key informants (health professionals) from the clinic indicated that such a taboo prevented pregnant women from reaching the nearest health facility at the earliest possible time. This reduced the opportunities of pregnant women of getting transport assistance from neighbors to the nearest health facility. One middle aged female who participant from the focus group discussions (Grace pseudo name) had this to say:

...if a pregnant woman was bid farewell and answered back, it was literally saying that the pregnant woman would not make it during labour.

The majority of the respondents noted that pregnant women were not allowed to escort visitors. The study found out that accompanying visitors would cause the unborn child to accompany all pregnancies that were due in the same month the child is to be born. This led to a situation highlighted by the key informants (health care workers) as false labour pains. This taboo was well entrenched in the Tonga society. Ironically the key informants further reported that this taboo resulted in most women not exercising which led to the swelling of legs during pregnancy. One key informant (nurse)

reported the importance of exercising when she highlighted that:

It has been clinically proven that exercises have positive benefits on the mother during delivery.

Putting hands on the back taboo was reported to have a role leading to maternal mortality. This taboo was deeply rooted in the Tonga culture. When asked why it was not permissible for an expectant woman to hold her hands behind her back, the study noted that the act showed displeasure to the call of reproduction on the part of the pregnant woman. The focus group discussions revealed that such discontentment could result in the pregnant woman suffering from high blood pressure which could result in miscarriages. This reflected badly on the husband and or extended family. One pregnant woman (Rudo pseudo name) from the focus group discussions of young women indicated that:

...my friend was displeased when she got pregnant with her fifth child, she was seen to unconsciously hold her hands on her back, but no one took her seriously until she had a miscarriage.

The study further revealed that women heavy with child were not supposed to dig the “*musikka*” tree which is a popular fruit tree in Binga. The “*musikka*” tree was reported to be used as an additional source of vitamins. The roots were used to prepare sour porridge. This cultural taboo was described by key informants (Nurses) to prevent women from exercising. In some instances, the pregnant woman could be single with no one to dig the tree for her in order to have vitamins. On the other hand, focus group discussion revealed that if pregnant women dug the “*musikka*” tree they were likely to give birth to preterm babies. This was emphasized by one middle aged female respondent (Nelly pseudo name) from the focus group discussion who expressed that:

...allowing pregnant women to dig the musikka tree was an indication that the clan was not in support of the woman’s pregnancy.

The research also noted another theme of cultural taboos that were observed during the post-natal care period. The study found out that the post-natal care taboos contradicted with the conventional post-natal care health care visits. The study also noted that the cultural post-natal care taboos delayed the mother and newborn child to access to post-natal care services. Another sub theme that came out of the study was that cultural post-natal care taboos limited pregnant women from exercising.

The majority of the respondents reported that it was a necessity for the Tonga people to observe the cultural post-natal care taboo of putting a rope on the gate of their homestead to signify the presence of a newborn baby. Upon further investigation the respondents reported that one rope indicated the presence of a baby boy while two ropes would be a sign of a baby girl. The key informants (Spiritual birth

attendants) indicated that newborn babies were not supposed to be seen by everyone before their umbilical cord dried up. Failure to adhere to this taboo resulted in one being suspected of witchcraft if anything happened to the child after their departure. This taboo was reported by the key informants (village health workers) to delay access to maternal health care. In situations where a child is born to a young couple with no knowledge of early detection of diseases like jaundice, such a taboo delayed the mother and child from receiving early treatment. One key informant (village health worker) had this to say:

Preventing people from visiting the homestead with a newborn child had its pros and cons as it made life difficult for people who did not have a strong family network support.

The study found out that the Tonga people adhere to the cultural post-natal care taboo of keeping the newborn child indoors until the umbilical cord dried up. When probed further the respondents revealed that the number of days that the child spent indoors was determined by the sex of child. If the child was a girl, she would have to stay indoors for fourteen days while a boy child was reported to stay indoors for seven days. This taboo was reported by key informants (village health workers) to delay women to seeking post-natal care services at the clinic. The more the child stayed indoors, the more the child’s chances of missing his or her post-natal care visits that are offered at three and seven days after the birth. The key informants (health care workers) at the clinic reiterated that if the child was not sucking breast milk very well, the child could starve to death while adhering to this taboo. It was also noted that in the eventuality of the child developing jaundice within three days of birth, this meant that the child was going to have late treatment. This taboo also made the mother of the newborn to miss post-natal health care services like being checked for post-partum haemorrhage and postpartum depression, which could result in postpartum mortality. One young female respondent from the focus group discussions (Jane pseudo name) who followed this taboo alluded to the fact that:

...I was instructed by my in-laws to keep the infant indoors until the umbilical cord dried.

Taboos with cultural significance in the Tonga Society

The research brought out an interesting sub theme of food preparation taboos followed in household that had pregnant women. In the eventuality of tabooed foods being prepared in households that had pregnant women; the study found out that they were more likely to eat with dried vegetables. The focus group discussions however revealed that tabooed foods were rarely prepared at homesteads that had pregnant women, as compared to homesteads that did not have pregnant women. Upon further investigations it was highlighted that this was done so that pregnant women would not be tempted to consume tabooed foods. One key informant (community elder) noted that;

Cultural habits like not cooking tabooed foods while a household member was pregnant made sure that the whole household adhered to food taboos.

To ensure compliance of the food preparation taboos, the study found out that food is prepared outside the house so that the whole clan can see and smell what is being prepared. Food preparation amongst the Tonga people is also prepared in a common pot for all the household members. Upon further probing the study found out that the food preparation taboos also made sure that the spirit of togetherness is reinforced in the Tonga culture as anyone who is hungry could join the meal as it would have been prepared outside where everyone could smell and see the food. One key informant (community elder) noted that:

Cultural habits like cooking in the same pot outside the house made sure that pregnant women adhered to food taboos.

The Traditional birth attendants on the other hand brought out an interesting aspect where they reported that dietary meat taboos were put in place in order to maintain stability and order in households. This was done to ensure that pregnant women would not demand food that was beyond the husband reach. One key informant (Traditional birth attendant) reported that:

In the wisdom of the elderly, dietary meat taboos were put in place so as to avoid tension in families...

The study found out that most women did not consume starchy foods during their third trimester of pregnancy. The foods most prohibited were from heavy grains like maize, sorghum and millet. All the focus group discussions concurred to this notion as they explained that starchy foods had negative side effects during the delivery, especially when eaten on the morrow. Hence for hygienic purposes during delivery this taboo was adhered to. It was also interesting to note that the key informants (Traditional birth attendance) believed that if pregnant women did not follow starchy food taboos, they were more likely to mess themselves during delivery. Upon further probing the key informants (Chiefs and village heads) indicated that this was a hygienic precaution that was taken by Traditional birth attendance during delivery as they did not have any protective clothing. One key informant (Traditional birth attendant) reported that:

... foods high in carbohydrates were not to be consumed as pregnant women would push her bowels instead of the child during delivery.

It was also noted that pregnant women were not expected to cut meat alone, without anyone assisting them as it resulted in women giving birth to selfish children. Focus group discussions brought out another theme, where this was done to ensure pregnant women get assistance to cut meat so as to encourage sharing amongst family members. This kept the ubuntu spirit of the Tonga people of eating together. The study also found out that it was a monitoring strategy that

ensured adherence to food taboos by pregnant women. One key informant (Traditional birth attendant) had this to say;

... it is taboo to cut meat alone while pregnant as it results in women giving birth to children with bad character traits.

Discussion

The study found out that food taboos were followed by most pregnant Tonga women despite their nutritional effects. This is in agreement with Nejimu, et al (2012) and Zinyemba, (2020) who noted that food taboos are followed in most communities despite their negative effects of maternal mortality and morbidity. It can thus be noted that pregnant women feared the consequences of not adhering to food taboos as compared to maternal mortality and morbidity. Maternal health can thus never be achieved unless food taboos are understood beyond the current body of knowledge and the reasons behind their continuity from an Afro centric perspective. There is thus need for a balance of the Afro centric dimension of taboos and the need to adhere to the standards of pre- and post-natal care.

Another theme that came out of the study was that pregnant women were not consuming a balanced diet due to food taboos. In line with such arguments Phuong et al, (2017) and Dodzo et al, (2016) highlighted that beliefs and social norms were the main deterring factors that prevented pregnant women from consuming a balanced diet. Ironically beliefs and cultural taboos have a significant influence on pregnant women despite their status in the community.

Most animal products like eland; zebra; elephant; bush pig; tortoise, hippopotamus and fish were not consumed by pregnant women because of the negative consequences that were associated with non-compliance. On the contrary studies by Djossinou et al, (2020) revealed that lack of a balanced diet during pregnancy affects the mother's birth weight which in turn influences the infant's birth size. Lawrence and Worsley, (2020) further report that, poor nutrition during pregnancy has a negative influence into adult life, such individuals have a high probability of being prone to a number of diseases.

Dietary starchy food taboos were also reported to have a negative effect on pregnant women. This resulted in pregnant women not consuming most heavy grains. In contrast to studies by Lawrence and Worsley, (2020) who noted the need for heavy grains so that pregnant women gain approximately 12, 5 kilograms over the course of their pregnancy.

Another theme that came out of the study was the cultural taboo of escorting visitors. This taboo was reported to result in most women not physically exercising during pregnancy. The act of moving up and down while escorting visitors can be a form of physical exercise that can prevent the swelling of legs. This is in line with studies by Lawrence and Worsley,

(2020) who demonstrated the importance of physical exercise during pregnancy.

The study also brought out a number of cultural taboos like bidding farewell taboo, escorting visitor's taboos, hands on the back taboo which precipitated the delay of women to access maternal health care services leading to maternal mortality. In support, Ganle, (2015) reported that cultural beliefs resulted in maternal mortality and morbidity. Purnima, (2017) further indicated that pregnant women first seek maternal health services in the community which concurs with their cultural taboos before accessing conventional maternal health care services. Such a body of knowledge shows that pregnant women delay accessing conventional maternal health care services as they first seek other health services in the community before accessing conventional health care services.

The study found out that the Tonga people adhere to the taboo of keeping the newborn child indoors for seven days or more until the umbilical cord dried up. This taboo contradicts the post-natal care standards where the mother and child are supposed to receive post-natal care services on the third day after delivery (World Health Organisation, 2018). The research further noted that advice given by Traditional birth attendants and Spiritual birth attendants in communities, in most instances, contradicted the advice that pregnant women receive from conventional health care workers. Concurrently, WHO, (2018) notes that maternal health care standards contradict the maternal health care services rendered in the community. This leaves pregnant women in a dilemma of choice on maternal health issues. Such a dilemmas of choice results in maternal mortality and morbidity as pregnant women are not clear on which type of health care system to follow and at which particular point in time, they should adhere to it. It can thus be noted that taboos had a pivotal role in the delay of pregnant women's access to maternal health care.

Another theme that came out of the study was that taboos had a significant part in maintaining order and peace in the community. From Afro centric perspective taboos were seen as prohibitions that maintained order as behind every taboo there were ethics and values that needed to be maintained in the community. As scholars like Schiele (2017) highlight that using the Afro centric approach will bring out the underlying reasons behind the adherence of taboos in communities.

Recommendations

Based on the findings that pregnant women lack knowledge on the importance of having a balanced diet during pregnancy there is need for health education in the communities so that pregnant women make an informed decisions in their quest for maternal health. Such a gap of knowledge in maternal health care can only be addressed by a people centered participatory approach in maternal health care.

Following the results that show that we have more than one health care system in rural communities offering maternal health services. This shows a gap in policy where the government of Zimbabwe is not clear on its current position of maternal health care services offered in the communities by Traditional birth attendants and Spiritual birth attendants. Under such circumstances there is need for clear roles to be set for all the providers of maternal health care in the communities. There is also need for coordinated approach for pregnant women to clear on the pros and cons of each health care system so that they can make an informed decision when to make use of which health care system.

From the findings it can be noted that food and cultural taboos play a significant role in communities as the consequences of non-adherence far outweigh maternal mortality and morbidity which are the consequences of conventional maternal health care. There is therefore need to understand pregnant women's culture from an Afro centric point of view in order for providers of maternal health care to render maternal health care services that are acceptable and appropriate to pregnant women in their communities.

Finally, there is need for more culture specific research to determine the role and impact of beliefs and cultural taboos in maternal health.

Conclusion

In conclusion, it can be noted that there are positive and negative effects of food and cultural taboos which cannot be ignored. They define the health seeking behaviours of communities. The study hence concludes that there is need for food and cultural taboos to be well researched beyond the current body of knowledge, so that appropriate strategies can be developed that disseminate information of taboos that contribute to maternal mortality at the same time reinforcing taboos that preserve our cultural heritage. If maternal mortality rates are to decline in Zimbabwe this balance has to be achieved. The study therefore argues that taboos should not be viewed at face value with a bias to conventional or mainstream theories of marginal health. Rather they should be critically analysed and unpacked to decipher the content of the knowledge within them for maternal health care to be achieved.

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