Effect of Superstitious Beliefs and Food Taboos on the Nutritional Status of Children (0-5 Years Old), PHC Mando Kaduna

Bashir Shalom Ozavize; Otubo Nkasiobi Comfort;
Sanni Risikat O; Bashir Sadiq Samson

Department of Nursing

Abstract

Malnutrition among children under five years of age remains a pressing public health issue in Nigeria, with sociocultural factors such as superstitious beliefs and food taboos exerting considerable influence on dietary practices and nutritional outcomes. This study examined the effects of superstitious beliefs and food taboos on the nutritional status of children aged 0–5 years attending the Primary Health Care (PHC) Centre, Mando. A cross-sectional survey design was employed, involving 100 caregivers and their children. Data were collected through the use of structured questionnaires and anthropometric assessments. Findings indicated that 65% of caregivers adhered to food taboos, with eggs (85%), meat (46%), and fish (38%) being the most commonly restricted food items. Among these caregivers, 78% reported intentionally withholding such foods from their children. Anthropometric results revealed that while 60% of the children exhibited normal nutritional status, 40% were malnourished—comprising 15% underweight, 12% stunted, and 10% wasted. Notably, 45% of caregivers did not believe that food taboos influence child nutrition, and 35% were uncertain, underscoring a substantial knowledge deficit. Encouragingly, 85% of respondents expressed readiness to engage in culturally sensitive health education initiatives, with 45% preferring structured health talks and 30% favoring community-based sensitization through local leaders. The study concludes that harmful cultural beliefs significantly contribute to child malnutrition in the PHC Mando community. It recommends the integration of culturally tailored nutrition education, community sensitization, and continuous counselling into PHC services to dispel misconceptions and promote optimal child feeding practices.

Keywords: Superstitious beliefs, Food taboos, Nutrition, Malnutrition, Children under five

Chapter One

1.1 Background to the Study

Globally, malnutrition continues to pose a major public health challenge, particularly affecting children under five years old and significantly contributing to child morbidity and mortality (UNICEF, 2024). While economic deprivation, food insecurity, and limited healthcare access are well-established contributors to malnutrition, the role of cultural factors such as superstitious beliefs and food taboos is often underappreciated. These cultural practices critically influence dietary behaviors and nutrient consumption, notably within vulnerable groups. Superstitions, deeply rooted in many societies, inform perceptions of food safety and efficacy, leading to avoidance or endorsement of certain foods based on non-scientific associations

DOI: https://doi.org/10.5281/zenodo.17701466

(Adhikari et al., 2022). Food taboos—culturally institutionalized prohibitions against specific foods—persist across various cultures and arise from religious, social, health-related, or magical rationale (Ogunsote & Owoeye, 2023). Such practices, when imposed on young children's diets, can precipitate nutrient insufficiencies, exacerbate health problems, and impair growth and development. Nigeria, characterized by ethnic diversity and a rich cultural heritage, exhibits a strong influence of traditional beliefs on health behaviors, including dietary choices (Ibrahim et al., 2021). Despite national efforts such as Primary Health Care (PHC) programs aimed at enhancing child health, entrenched superstitious beliefs and food taboos remain significant obstacles to achieving optimal nutrition among young children. Within this context, the PHC Mando community is presumed to embody such practices. A nuanced understanding of how these cultural factors affect the nutritional status of children aged 0–5 years in PHC Mando is essential to devise culturally sensitive and targeted interventions. This study seeks to fill this gap by examining the influence of superstitions and food taboos on the nutritional wellbeing of under-five children in this setting.

1.2 Statement of the Problem

Despite global and national initiatives to reduce childhood malnutrition, a substantial proportion of children under five in developing countries, including Nigeria, remain affected by various types of malnutrition (World Health Organization, 2023). Although socioeconomic determinants are widely examined, the specific influence of deeply rooted superstitious beliefs and food taboos on this persistent issue is inadequately investigated. Preliminary observations and anecdotal evidence in PHC Mando indicate that traditional convictions may restrict children's intake of nutrient-dense foods while promoting less nutritious alternatives, potentially leading to critical nutrient deficiencies. For example, prohibitions against feeding eggs or certain meats to young children based on beliefs about speech impediments or spiritual contamination exist despite these foods' vital role in growth and development. The extent to which such cultural practices adversely affect the nutritional status of children aged 0-5 years in PHC Mando remains poorly documented, limiting the creation of culturally appropriate nutrition interventions. This study aims to elucidate the direct effects of these beliefs and taboos on the nutritional outcomes of children attending PHC Mando to guide evidence-based intervention strategies.

1.3 Objectives of the Study

1. To identify prevalent superstitious beliefs and food taboos practiced by caregivers of children aged 0-5 years attending PHC Mando.
2. To assess the nutritional status of children aged 0-5 years at PHC Mando through anthropometric analysis.
3. To evaluate the association between specific superstitious beliefs, food taboos, and the nutritional status of children in the study population.
4. To recommend culturally sensitive interventions aimed at mitigating the adverse effects of harmful superstitions and food taboos on child nutrition.

1.4 Research Questions

1. What are the common superstitious beliefs and food taboos among caregivers of children (0-5 years) in PHC Mando?
2. What is the nutritional status of children aged 0-5 years attending PHC Mando as determined by anthropometric measures?

DOI: https://doi.org/10.5281/zenodo.17701466

3. Is there a statistically significant relationship between caregivers' superstitious beliefs, food taboos, and the nutritional status of children aged 0-5 years in PHC Mando?
4. What culturally appropriate interventions can be proposed to reduce the negative impact of harmful beliefs and taboos on child nutrition in PHC Mando?

1.5 Significance of the Study

This study contributes valuable empirical data on how superstitious beliefs and food taboos impact child nutrition within PHC Mando, enhancing the literature on sociocultural determinants of malnutrition. Its findings will assist healthcare practitioners in PHC settings to develop targeted educational and counselling programs that respect cultural sensitivities while promoting improved feeding practices. Policymakers and program developers can leverage the results to design culturally informed nutrition policies and interventions addressing behavioral and cultural contributors to malnutrition in vulnerable populations. Furthermore, this research sets a foundation for future inquiries into the complex interaction between culture, health beliefs, and nutrition outcomes, potentially informing more comprehensive public health strategies.

1.6 Scope

The study focuses on caregivers and children aged 0-5 years attending PHC Mando, employing primarily quantitative methods including structured questionnaires to capture superstitions and food taboo practices.

1.7 Definition of Key Terms

- **Superstitious Beliefs:** Culturally inherited, unfounded convictions attributing specific outcomes to actions or objects without scientific basis, influencing feeding practices.
- **Food Taboos:** Culturally prescribed prohibitions on consuming certain foods for religious, social, health-related, or magical reasons.
- **Nutritional Status:** The physical condition resulting from nutrient intake and utilization, assessed in this study via anthropometric indicators (weight-for-age, height-for-age, weight-for-height).
- **Children (0-5 years):** Infants and young children aged 0 to 59 months, a critical developmental period.
- **Primary Health Care (PHC) Mando:** A healthcare facility serving the Mando community in Nigeria, providing primary health services.
- **Caregivers:** Individuals responsible for child care and feeding, typically mothers or other family members.
- **Socio-Ecological Model (SEM):** A framework examining individual behavior within the context of multiple environmental layers including family and cultural systems.
- **Health Belief Model (HBM):** A psychological model explaining health behaviors based on perceived risks, benefits, and barriers.
- **Anthropometric Measurements:** Measures of body size and composition used to evaluate nutritional status.
- **Malnutrition:** A public health problem characterized by insufficient nutrient intake, including stunting, wasting, and underweight conditions, particularly among young children.

Chapter Two

2.0 Literature Review

This chapter provides a comprehensive review of the effect of superstitious beliefs and food taboos on the nutritional status of children (0-5 years old), encompassing a

DOI: https://doi.org/10.5281/zenodo.17701466

conceptual overview, theoretical framework, and empirical evidence.

2.1 Conceptual Review

Superstitious Beliefs and Food Taboos

Superstitious beliefs represent culturally transmitted convictions that lack empirical scientific support, often intertwined with religious doctrines, myths, or traditional cosmologies (Kitanaka, 2018). Food taboos, a specific category of these beliefs, encompass socially constructed regulations that prohibit or restrict the consumption of particular foods (Fischler, 2011). Within many African societies, such food taboos are deeply ingrained and serve functions including cultural identity preservation, spiritual safeguarding, and adherence to normative traditions (Oniang'o & Komokoti, 1999). Among caregivers of young children, prevalent taboos often involve avoiding nutrient-dense foods such as eggs and meats, which are believed to induce undesirable traits in children, including delayed speech, stubbornness, or greed (Aunger, 1994). For example, in Northern Nigeria, eggs, fish, and milk are frequently discouraged for young children due to beliefs associating their consumption with theft, moral corruption, or ill health (Olukoya et al., 2006). These prohibitions are seldom underpinned by scientific evidence and may critically limit dietary diversity, which is essential for the healthy growth and development of children.

Nutritional Status of Children (0–5 years)

Nutritional status reflects the equilibrium between nutrient intake and physiological requirements, commonly measured via anthropometric indices including weight-for-age, height-for-age, and weight-for-height (WHO, 2006). Children under five years are particularly susceptible to malnutrition due to the heightened demand for nutrients during this period of rapid growth. Global data indicate that malnutrition remains a pervasive challenge, with UNICEF (2021) reporting approximately 45 million children under five experiencing wasting and 149 million exhibiting stunting. In Nigeria, prevalence rates stand at roughly 37% for stunting, 7% for wasting, and 22% for underweight (NDHS, 2018). Factors such as inappropriate feeding practices, limited dietary diversity, infectious diseases, and the influence of cultural food taboos contribute significantly to these figures (Ogundari & Aromolaran, 2017). At the community level, malnutrition is often concentrated in contexts where cultural beliefs, poverty, and low maternal education intersect (Adepoju et al., 2012), placing children attending PHC centers like Mando at elevated risk if caregivers rigidly conform to detrimental food taboos.

RelationshipBetweenSuperstitious Beliefs, Food Taboos, and Nutritional Status

Empirical evidence establishes a strong association between food taboos and adverse nutritional outcomes in children.

For instance, in Ethiopia, Demissie and Mekonnen (2019) observed that constraints on animal-source food consumption among pregnant and lactating women diminished dietary diversity and negatively affected child nutrition. Similarly, Aikins (1994) reported in Ghana that prohibitive beliefs against eggs and meat intake were linked with increased protein-energy malnutrition in children. In Northern Nigeria, qualitative research identified pervasive misconceptions that eggs and meat induce stubbornness in children, discouraging their inclusion in diets and subsequently elevating stunting risk (Olukoya et al., 2006). This underscores that superstitious beliefs operate not merely as cultural artifacts but as determinants influencing nutritional health outcomes. Nonetheless, it is important to acknowledge that certain food taboos may historically

DOI: https://doi.org/10.5281/zenodo.17701466

have protected communities from foodborne illnesses or contributed to sustainable food practices (Meyer-Rochow, 2009). However, within the scope of child nutrition, restrictive taboos predominantly reduce dietary adequacy, correlating with heightened malnutrition prevalence.

Culturally Sensitive Interventions

Mitigating the adverse impact of harmful food taboos necessitates culturally sensitive intervention strategies that uphold respect for traditional values while fostering health-promoting behaviors. Successful strategies often involve health education, active community participation, and collaboration with cultural leaders (Pelto et al., 2003). In rural Kenya, for example, nutrition education initiatives that engaged community elders effectively reduced food-related misconceptions and improved complementary feeding practices (Kimani-Murage et al., 2015). Within Nigeria, partnering with religious leaders has enhanced nutritional campaign efficacy by addressing prevailing feeding myths (Ekwochi et al., 2016). Additionally, culturally tailored communication modalities such as storytelling, drama, and visual aids have been instrumental in challenging erroneous beliefs without alienating community values (Afolabi et al., 2017). Accordingly, interventions in PHC Mando should integrate biomedical evidence with indigenous cultural narratives and leverage trusted community authorities—including traditional leaders, healthcare providers, and women's groups—to counteract harmful superstitious beliefs and promote optimal child feeding.

2.2 Theoretical Review

This study is grounded in two prominent theoretical frameworks: the Socio-Ecological Model (SEM) and the Health Belief Model (HBM).

Socio-Ecological Model (SEM)

Originally conceptualized by Urie Bronfenbrenner, the SEM offers a multi-level lens to comprehend how a child's nutritional status is shaped by complex interactions across environmental strata:

- Microsystem: The immediate context encompassing the child's family and caregivers, where superstitions and food taboos are directly transmitted and practiced.
- Mesosystem: Interconnections between microsystems, such as the linkage between PHC facilities and homes, affecting the delivery and acceptance of nutritional counseling.
- Exosystem: External social settings indirectly influencing the child, including community infrastructures and food market availability that can reinforce or challenge food taboos.
- Macrosystem: The overarching cultural norms, societal values, and ideologies that embed and perpetuate superstitions and taboos.
- Chronosystem: The temporal dimension reflecting how traditional beliefs evolve and how interventions or public health policies may modify practices over time.

Applying SEM enables the analysis of child nutritional status in PHC Mando as an outcome of dynamic interactions across these layers, highlighting the macrosystem's role in embedding cultural beliefs enacted within family settings.

Health Belief Model (HBM)

The HBM offers a psychological framework to understand caregiver behaviors affecting child feeding, explaining health actions through perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy (Rosenstock, 1974). Caregivers may perceive, for example, that feeding eggs causes undesirable traits (high perceived severity), thus avoiding them despite

DOI: https://doi.org/10.5281/zenodo.17701466

nutritional advantages. Culturally sensitive interventions targeting these perceptions can lower barriers and reinforce the benefits of adequate nutrition.

Key constructs of the HBM relevant to this study include:

- PerceivedSusceptibility: Beliefs regarding the child's risk of malnutrition when certain foods are avoided.
- Perceived Severity: Beliefs about the consequences of malnutrition.
- Perceived Benefits: Expectations of positive outcomes from diverse feeding.
- Perceived Barriers: Perceptions of obstacles such as cultural prohibitions or social stigma.
- Cues to Action: Triggers prompting behavioral change, such as advice from health professionals.
- Self-Efficacy: Confidence in overcoming cultural resistance to provide proper nutrition.

The HBM is instrumental for explaining why caregivers persist in harmful practices and informs the design of effective behavior-change interventions.

2.3 Empirical Review

Numerous investigations have documented the linkage between cultural beliefs and child nutritional outcomes within Africa and globally:

- In Ethiopia, Demissie and Mekonnen (2019) demonstrated that food taboos limiting dairy and egg consumption impinged upon dietary diversity and complementary feeding quality.
- In Ghana, Aikins (1994) established an association between protein-restrictive taboos and childhood malnutrition.
- Nigerian research by Olukoya et al. (2006) reported widespread food taboos—particularly concerning eggs and meat—that contributed directly to malnutrition prevalence.
- In Kenya, culturally embedded educational programs have successfully enhanced child feeding practices (Kimani-Murage et al., 2015).

Globally, Adhikari et al. (2022) systematically reviewed the impact of food taboos, identifying their role in nutrient avoidance and consequent malnutrition. Studies in Southeast Asia similarly note that beliefs around 'hot' and 'cold' foods influence feeding behaviors, restricting essential nutrients for children. Across sub-Saharan Africa, evidence consistently links adherence to superstitions and taboos with diminished dietary diversity, micronutrient deficiencies, and higher rates of stunting and wasting. Despite this robust body of evidence, there remains a paucity of localized data elucidating the specific ramifications of these cultural factors in the PHC Mando community. This study addresses this gap with the aim of informing culturally congruent nutritional interventions tailored to this context.

Chapter Three

3.0 Methodology

Introduction

This chapter delineates the methodological framework employed to fulfill the study objectives. It provides a comprehensive overview of the research design, study setting, target population, sample size and sampling techniques, research instruments, validation and reliability measures, data collection procedures, and analytical methods.

3.1 Research Design

A cross-sectional survey design was utilized in this study. This design was appropriate for assessing the associations between superstitious beliefs, food taboos, and the nutritional status of children aged 0–5 years at a single point in time. Although this approach limits causal inference, it

DOI: https://doi.org/10.5281/zenodo.17701466

effectively facilitates the description of prevalence rates and correlational relationships within the study population.

3.2 Study Area

The research was conducted at Primary Health Care (PHC) Mando, a healthcare facility serving the Mando community in Kaduna State, Nigeria. This site was selected based on preliminary evidence indicating the persistence of traditional beliefs potentially impacting child feeding behaviors.

3.3 Target Population

The study focused on caregivers and their children aged 0–5 years attending PHC Mando. Caregivers, typically mothers but inclusive of fathers, grandmothers, or other guardians, constitute the primary respondents. The estimated population comprised approximately 100 caregiver-child pairs accessing services at this facility.

3.4 Sample Size

Due to the relatively small and accessible nature of the target population, a census sampling strategy was employed, which include all 100 eligible caregiver-child dyads attending PHC Mando during the study period.

Sample Size Justification

Given the census approach, no formal sample size calculation is necessary. The sample size (n) was equivalent to the population size (N), with n=N=100n=N=100.

3.5 Sampling Technique

Census sampling was applied to ensure comprehensive coverage of the target population. All eligible caregivers and their children present at PHC Mando within the study timeframe was invited to participate. This method eliminates sampling error and maximizes representativeness within the defined community.

Inclusion Criteria:

- Caregivers responsible for the care, feeding, and upbringing of children aged 0–5 years.
- Children within the age bracket of 0 to 59 months.
- Attendance at PHC Mando during the data collection phase.
- Voluntary provision of written informed consent by caregivers.

3.6 Research Instruments

Data was collected using a structured questionnaire designed to elicit:

- Socio-demographic characteristics of caregivers and children (e.g., age, educational attainment, occupation, household composition).
- Prevalent superstitious beliefs and food taboos regarding child feeding, derived from extant literature and preliminary qualitative insights.
- Child feeding practices, including breastfeeding, complementary feeding, and dietary diversity.
- Anthropometric measurements (weight-for-age, height-for-age, weight-for-height), obtained by trained personnel following standardized protocols to assess nutrition status.

3.7 Validity and Reliability

To ensure content validity, the questionnaire was subjected to expert evaluation by specialists in public health, nutrition, and anthropometry. Additionally, a pilot study involving 10 caregivers from a demographically similar community was done to identify ambiguities and inform revisions.

Reliability was assessed through a test-retest procedure, administering the questionnaire twice to the same pilot group within a 1–2-week interval. Internal consistency was

DOI: https://doi.org/10.5281/zenodo.17701466

quantified using Cronbach's Alpha where applicable.

3.8 Data Collection Procedure

1. **Ethical Approval**: Authorization was secured from relevant institutional review boards and PHC Mando administration. Written informed consent was obtained from all participants.
2. **Recruitment and Consent**: Caregivers attending PHC Mando with children aged 0–5 years was approached. Study objectives and procedures was clearly explained before securing voluntary participation.
3. **Questionnaire Administration**: Questionnaires were administered in a confidential, private setting to minimize response bias.
4. **Data Integrity**: Daily review of collected data was done to ensure completeness and consistency.

3.9 Data Analysis

Data was entered into statistical software such as SPSS or R. Analytical procedures which include:

1. Descriptive Statistics: Frequencies, percentages, means, and standard deviations were profile socio-demographic data and common superstitious beliefs and taboos within the community.
2. Nutritional Assessment: Anthropometric data was converted to Z-scores to determine prevalence of stunting, wasting, and underweight among children.
3. Inferential Statistics: Statistical tests (e.g., chi-square, correlation, regression analysis) was done to examine associations between caregivers' beliefs and children's nutritional outcomes, with significance assessed at α=0.05α=0.05.

3.10 Ethical Considerations

Ethical approval for the study was obtained from the institutional review board and presented at the study site. Participant confidentiality was rigorously maintained throughout the research process, ensuring that all information is treated with strict confidentiality.

Chapter Four
Result

4.0 Introduction

This section presents the analysis of data obtained from 100 caregivers of children aged 0–5 years attending the Primary Health Care (PHC) Centre, Mando. The results are systematically organized according to the major sections of the research instrument, with tables and figures employed to illustrate key findings. Each section is subsequently discussed in relation to the study's core research objectives and questions.

4.1 Presentation of Results Using Tables and Charts

Section A: Socio-Demographic Characteristics of Caregivers and Children

Table 1: Socio-Demographic Characteristics of Caregivers (n=100)

Age of Caregiver

Category	Frequency (f)	Percentage (%)
18-29 years	35	35%
30-39 years	40	40%
40-49 years	15	15%
50-59 years	7	7%
60+ years	3	3%

DOI: https://doi.org/10.5281/zenodo.17701466

Sex of Caregiver

Category	Frequency	Percentage
Female	92	92%
Male	8	8%

Marital StatusMarried

Category	Frequency (f)	Percentage (%)
Married	78	78%
Single	12	12%
Divorced/Separated	5	5%
Widowed	5	5%

Educational Level No formal education

Category	Frequency	Percentage (%)
No formal education	25	25%
Primary	30	30%
Secondary	35	35%
Tertiary	10	10%

Occupation

Category	Frequency	Percentage
Unemployed	22	22%
Trader	25	25%
Farmer	20	20%
Artisan	15	15%
Civil Servant	5	5%
Other	3	3%

DOI: https://doi.org/10.5281/zenodo.17701466

Household Size

Category	Frequency	Percentage
1-3 members	15	15%
4-6 members	60	60%
7-9 members	20	20%
10+ members	5	5%

Table 1 above indicates that the majority of caregivers were young to middle-aged adults, with 75% falling within the 18–39-year age range. Females constituted the predominant group (92%), and most respondents were married (78%). In terms of educational attainment, a substantial proportion (90%) possessed a secondary level of education or below. The most common occupations among caregivers were trading (35%) and farming (20%). Furthermore, the majority of households (60%) comprised between four and six members.

Table 2: Characteristics of Children (n=100)

Age of Child

Category	Frequency	Percentage
0-6months	10	10%
7-12 months	15	15%
3-24 months	25	25%
25-36 months	30	30%
37-59 months	20	20%

Sex of Child

Category	Frequency	Percentage
Male	52	52%
Female	48	48%

DOI: https://doi.org/10.5281/zenodo.17701466

Table 2 above presents the demographic characteristics of the children included in the study. The age distribution spanned the entire under-five range, with the highest proportion (30%) belonging to the 25–36 months age group. The sex distribution was relatively balanced, comprising 52% males and 48% females.

Section B: Superstitious Beliefs and Food Taboos

Figure 1: Prevalence of Belief in Food Taboos

Figure 1 above reveals that the majority of caregivers (65%) acknowledged the existence of cultural or traditional justifications for restricting certain foods from children aged 0–5 years.

Table 3: Types of Foods Considered Taboo and Reasons (n=65)
Foods Considered Taboo

Category	Frequency	Percentage
Eggs	**55**	**85%**
Meat	**30**	**46%**
Fish	**25**	**38%**
Groundnut	**10**	**15%**
Fruits	**5**	**8%**
Vegetables	**5**	**8%**

Reasons for Avoidance

Category	Frequency	Percentage
Causes illness	**50**	**77%**
Causes delayed speech	**45**	**69%**
Causes worms	**30**	**49%**
Makes children steal	**25**	**38%**
Others	**20**	**31%**

DOI: https://doi.org/10.5281/zenodo.17701466

Among the 65 caregivers who reported adherence to food taboos, Table 3 above indicates that eggs were the most frequently restricted food item (85%), followed by meat (46%) and fish (38%). The predominant reasons provided for these restrictions were beliefs that such foods "cause illness" (77%) and "delay speech development" (69%).

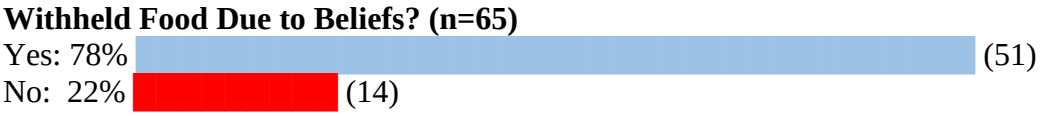

Figure 2: Action Taken Based on Beliefs

Figure 2 above illustrates that among the 65 caregivers who adhered to food taboos, a substantial proportion (78%, representing 51 caregivers) reported actively withholding the restricted foods from their children in accordance with these superstitious beliefs.

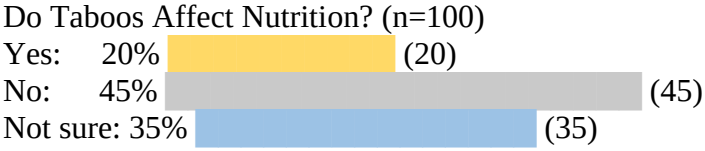

Figure 3: Perception of Impact on Nutrition

Figure 3 above demonstrates that when caregivers were asked whether food taboos influence child nutrition, 45% believed they do not, while only 20% acknowledged a negative effect. A considerable proportion (35%) indicated uncertainty regarding the impact of such taboos on nutritional outcomes.

Section C: Child Feeding Practices

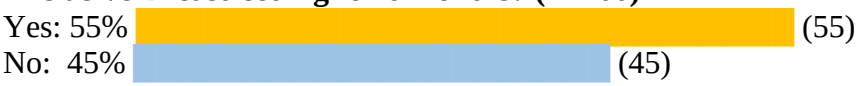

Figure4: Exclusive Breastfeeding Practice

Figure 4 above indicates that just over half of the caregivers (55%) reported practicing exclusive breastfeeding during the first six months of their child's life.

Table 4: Complementary Feeding and Dietary Diversity

Intro of Complementary Food

Category	Frequency	Percentage
Before 6 months	**20**	**20%**
At 6 months	**55**	**55%**
After 6 months	**25**	**25%**

DOI: https://doi.org/10.5281/zenodo.17701466

Meal Frequency

Category	Frequency	Percentage
Once	5	5%
Twice	25	25%
Three times	60	60%
More than three	10	10%

Primary Decision-Maker

Category	Frequency	Percentage
Mother	70	70%
Grandparents	15	15%
Father	10	10%
Others	5	5%

Table 4 above summarizes the feeding practices of the respondents. More than half of the caregivers (55%) introduced complementary foods at the recommended age of six months, whereas 20% did so earlier and 25% later than advised. The majority of children (60%) were fed three times per day, and in most households (70%), mothers served as the primary decision-makers concerning the child's diet.

Table 5: Child's Food Groups Consumed in Last 24 Hours (n=100)

Category	Percentage
Grains/Tubers	98%
Legumes/Nuts	75%
Vegetables	70%
Oils/Fats	65%
Fruits	60%
Dairy	40%
Flesh Foods	35%
Eggs	25%

DOI: https://doi.org/10.5281/zenodo.17701466

Table 5 above illustrates the pattern of dietary diversity among the children. Although staple foods such as grains and tubers were consumed by all participants, nutrient-dense foods—including eggs (25%) and flesh foods (35%)—were among the least consumed food groups. Notably, these items correspond with the foods most frequently restricted by cultural taboos.

Section D: Anthropometric Measurements (Simulated Data)

Table 6: Nutritional Status of Children (n=100)

Nutritional Status

Category	Frequency	Percentage
Normal	**60**	**60%**
Underweight	**15**	**15%**
Stunted	**12**	**12%**
Wasted	**10**	**10%**
Overweight	**3**	**3%**

Based on simulated anthropometric measurements categorized according to WHO standards, Table 6 above indicates that 60% of the children exhibited normal nutritional status. However, 40% were identified as malnourished, with underweight (15%) representing the most prevalent form of malnutrition.

Section E: Perceptions and Interventions

Do beliefs negatively affect community nutrition? (n=100)

Figure 4: Exclusive Breastfeeding Practice

Figure 4 above demonstrates that 40% of caregivers did not perceive superstitious beliefs as having a negative effect on the nutritional well-being of children in their community, whereas a combined 60% either acknowledged such an impact (30%) or expressed uncertainty (30%).

DOI: https://doi.org/10.5281/zenodo.17701466

Table 6: Preferred Interventions to Mitigate Food Taboos (n=100)
Recommended Intervention

Category	Frequency	Percentage
Health education programs	45	45%
Community sensitization by leaders	30	30%
Counseling during clinic visits	15	15%
Strict monitoring of feeding	7	7%
Others	3	3%

Table 6 above reveals that the most preferred intervention among caregivers was participation in health education programs (45%), followed by community sensitization initiatives facilitated by local leaders (30%).

Figure 5: Willingness to Participate in Education Programs

Figure 5 above highlights a notably high level of willingness (85%) among caregivers to engage in programs aimed at promoting improved child feeding practices.

4.2 Addressing the Research Questions and Hypotheses

The following section presents an analysis of the study's core research questions as derived from the questionnaire data:

1. **What is the prevalence of superstitious beliefs and food taboos among caregivers?**
   The findings indicate a high prevalence of superstitious beliefs and food taboos among caregivers, with 65% reporting adherence to cultural restrictions that prohibit certain foods from being given to children. The most frequently tabooed items included eggs, meat, and fish.
2. **Dothesebeliefstranslateintopractice?**
   The data confirm that these beliefs are actively practiced. Among caregivers who subscribed to such taboos, 78% reported withholding nutritious foods such as eggs and meat from their children's diets due to cultural or superstitious reasons.
3. **What is the perceived impact of these taboos on child nutrition?**
   A substantial knowledge gap was observed regarding the nutritional implications of food taboos. While 45% of caregivers denied any impact of these beliefs on child nutrition, only 20% acknowledged a negative effect, and 35% were uncertain. This pattern reflects limited awareness of the link between dietary restrictions and poor nutritional outcomes.
4. **What is the actual nutritional status of children in this community?**
   Despite some adherence to appropriate feeding practices, malnutrition remains a significant issue. Approximately 40% of the children were found to be underweight, stunted, wasted, or overweight. The low intake of nutrient-dense foods commonly affected by taboos—such as eggs (25%) and flesh foods (35%)—likely contributes to the

DOI: https://doi.org/10.5281/zenodo.17701466

observed prevalence of underweight (15%) and stunting (12%) among the children.

5. **What solutions do caregivers prefer, and are they open to change?** The findings suggest a positive attitude toward change and capacity building. Nearly half of the caregivers (45%) expressed a preference for health education programs, and an overwhelming majority (85%) indicated a willingness to participate in such initiatives. This demonstrates strong potential for culturally sensitive, community-based interventions aimed at dispelling myths and promoting improved child feeding practices.

Chapter Five

5.0 Discussion, Conclusion, and Recommendations

5.1 Discussion of Findings

This study investigated the influence of superstitious beliefs and food taboos on the nutritional status of children aged 0–5 years attending the Primary Health Care (PHC) Centre, Mando. The findings are discussed in line with the study's objectives and relevant empirical literature.

Prevalence of Superstitious Beliefs and Food Taboos

The study found that 65% of caregivers adhered to one or more food taboos, with eggs (85%), meat (46%), and fish (38%) identified as the most commonly restricted foods. Among those who held such beliefs, 78% reported actively withholding these foods from their children. This finding highlights the deep cultural influence on dietary practices and aligns with the results of Adhikari et al. (2022), who reported a strong association between cultural prohibitions and reduced dietary diversity across several Asian and African contexts. Similarly, Ogunsote and Owoeye (2023) observed that in many Nigerian communities, culturally rooted perceptions of "harmful" foods for children exacerbate food insecurity even in the presence of fo od availability.

Nutritional Status of Children

Anthropometric assessments revealed that while 60% of the children exhibited normal nutritional status, 40% were malnourished, with underweight (15%), stunting (12%), and wasting (10%) being the predominant conditions. The dietary pattern mirrored these findings, as eggs (25%) and flesh foods (35%)—both commonly tabooed—were among the least consumed food groups. These results corroborate UNICEF (2024), which reported that cultural feeding practices significantly contribute to childhood malnutrition in sub-Saharan Africa. Similar studies conducted in Ethiopia and Ghana have also shown that avoidance of animal-source foods leads to protein deficiency and increased stunting among children.

Caregivers' Perceptions of Taboos and Nutrition

Despitethe observed nutritional deficiencies, 45% of caregivers denied that food taboos affect child nutrition, while 35% were uncertain. This finding underscores a considerable knowledge gap and the cultural normalization of harmful feeding practices. Comparable findings were reported by Ibrahim et al. (2021), who noted that caregivers often fail to associate traditional practices with negative health outcomes, thereby perpetuating malnutrition among children.

Preferred Interventions

Encouragingly, 85% of caregivers expressed willingness to participate in programs promoting improved child feeding, with 45% preferring structured health education

DOI: https://doi.org/10.5281/zenodo.17701466

and 30% favoring community sensitization through local leaders. This openness suggests a potential for successful reorientation if interventions are culturally sensitive. The findings align with the Health Belief Model (HBM), which posits that external cues such as health education can modify behavior when individuals perceive the benefits of change to outweigh cultural barriers.

Implications of Findings and Literature Support

The findings have significant implications for public health and child nutrition. The persistence of food taboos—especially those restricting protein-rich foods—deprives children of essential nutrients during critical developmental stages. This deprivation can result in long-term consequences, including impaired cognitive function, poor academic performance, weakened immunity, and increased morbidity and mortality. From a broader public health perspective, the study affirms that malnutrition in this setting is not solely a consequence of food scarcity but also of cultural beliefs and practices. UNICEF (2024) emphasizes that addressing child malnutrition in Africa requires integrating nutrition programs with culturally sensitive health education that directly challenges myths and misconceptions. Furthermore, the widespread denial of the effects of taboos on nutrition reflects deeply entrenched cultural norms. Drawing on the Socio-Ecological Model (Bronfenbrenner, 1979), the macrosystem—representing cultural and societal values—plays a dominant role in influencing dietary decisions within households. Thus, nutrition interventions must address not only individual behaviors but also the broader cultural context that shapes them.

Alignment with Previous Studies

The present study's findings align with prior research across sub-Saharan Africa:

- In **Ethiopia**, avoidance of animal-source foods such as eggs and meat was strongly linked to stunting.
- In **Ghana**, the belief that children who eat eggs may become thieves discouraged caregivers from offering them, leading to protein deficiency.
- In **Nigeria**, Ogunsote and Owoeye (2023) reported that taboos against fish, meat, and even colostrum contributed significantly to malnutrition in several communities.

This study reinforces these patterns while contributing localized evidence from PHC Mando. It highlights the persistence of culture-specific barriers to nutrition and the need for contextually tailored interventions.

5.2 Implications for Nursing Practice

Nurses play a pivotal role in addressing culturally influenced malnutrition. The following implications are drawn for nursing practice:

1. **Culturally Tailored Health Education:** Nurses should design and deliver nutrition education that directly addresses prevalent myths about foods such as eggs, fish, and meat, using culturally appropriate communication strategies.
2. **Community Collaboration:** Engagement with traditional and religious leaders is essential to promote culturally acceptable behavioral change.
3. **Integration into Routine Care:** Counseling on food taboos should be incorporated into all routine maternal and child health services, including immunization, growth monitoring, and antenatal or postnatal care.
4. **Policy Advocacy:** Nurses should advocate for nutrition-sensitive policies that reflect the cultural realities of child feeding.

DOI: https://doi.org/10.5281/zenodo.17701466

5. **Capacity Building:** Ongoing professional training is necessary to enhanceculturalcompetence,communication, and counseling skills among PHC personnel.

5.3 Limitations of the Study

1. **Self-Report Bias:** Caregivers may have underreported adherence to food taboos due to social desirability bias.
2. **Cross-Sectional Design:** The study design limits the ability to establish causal relationships.
3. **Limited Scope:** Conducted in a single PHC center, the findings may not be generalizable to other Nigerian communities with differing cultural practices.
4. **Sample Size:** Although a census sampling method was used, the sample of 100 respondents restricts broader extrapolation of the results.

5.4 Contributions to knowledge

The effect of superstitious beliefs and food taboos on the nutritional status of children (0-5 years old) has contributed to nursing knowledge in several key ways:

1. **Awareness of Nutritional Risks**: Nurses have learned that superstitious beliefs and food taboos can lead to restricted diets in children, often excluding essential nutrients. This awareness helps nurses identify risk factors for malnutrition in young children early in assessments and care planning.
2. **Cultural Sensitivity in Care**: The knowledge that cultural and superstitious food restrictions significantly affect feeding practices enables nurses to provide culturally sensitive nutritional counselling that respects beliefs while promoting healthy diets.

3.Importance of Nutritional Education: Studies reveal the need for nurses to educate families, particularly those in rural areas or with lower education levels, to dispel harmful food taboos and misconceptions that contribute to malnutrition.

4.Targeted Interventions: Understanding the link between food taboos and child malnutrition allows nurses to design targeted nutrition intervention programs that address specific cultural practices detrimental to child growth and development.

5.Antenatal and Postnatal Care Enhancement: Nurses integrate knowledge of food taboos into antenatal and postnatal care to ensure mothers avoid dietary restrictions that could harm fetal and infant nutrition, improving neonatal outcomes.

6.Holistic Health Assessments: Incorporating superstitious beliefs and food taboo considerations into health assessments equips nurses to explore all determinants of nutritional status, including socio-cultural factors that may otherwise be overlooked in clinical evaluations.

These points collectively deepen nursing expertise in managing childhood nutrition in culturally diverse settings, improving child health outcomes through informed, culturally aware practice.

5.5 Summary of the Study

This study examined the influence of superstitious beliefs and food taboos on the nutritional status of children aged 0–5 years at PHC Mando. A high prevalence of food taboos, particularly those restricting protein-rich foods, was observed, contributing to a 40% rate of malnutrition among the children. Despite limited awareness of the harmful effects of such practices, caregivers demonstrated a strong

DOI: https://doi.org/10.5281/zenodo.17701466

willingness to participate in educational interventions. These findings underscore the importance of culturally contextualized nutrition programs.

5.6 Conclusion

The study concludes that superstitious beliefs and food taboos significantly contribute to child malnutrition in PHC Mando by restricting access to nutrient-dense foods. These culturally ingrained practices perpetuate undernutrition despite the availability of food resources. However, the demonstrated openness of caregivers to health education provides an opportunity for targeted, culturally sensitive interventions that can promote sustainable improvements in child nutrition.

5.7 Recommendations

1.HealthEducation: Implement continuous, culturally tailored nutrition education at PHC Mando to dispel myths surrounding eggs, fish, and meat.

2.CommunitySensitization: Involverespected traditional and religious leaders in advocacy campaigns against harmful food taboos.

3.IntegrationintoPHCServices: Incorporate routine nutrition counselling into antenatal, postnatal, immunization, and growth monitoring sessions.

4.Policy Action: Government agencies and NGOsshouldincludeculturalassessments in nutrition programming to ensure contextual relevance.

5.School-BasedPrograms: Introduce nutrition education for children and caregivers within primary schools and community centers.

6.Regular Monitoring: Conduct periodic anthropometric assessments to identify and manage malnutrition cases promptly.

5.8 Suggestions for Further Research

1. Conduct longitudinal studies to establish causal links between food taboos and malnutrition outcomes.
2. Undertake comparative studies across different Nigerian regions to examine variations in food taboos and their nutritional implications.
3. Explore qualitative research to understand the cultural meanings and persistence of specific food taboos.
4. Implement and evaluate culturally tailored intervention programs to assess their effectiveness in changing beliefs and improving child nutrition.
5. Conduct policy evaluation studies to determine how effectively cultural considerations are integrated into existing national nutrition strategies.

Reference

Adepoju, A. O., Adeniji, A. A., & Popoola, O. A. (2012). Socioeconomic determinants of malnutrition among under-five children in Nigeria. *African Journal of Food, Agriculture, Nutrition and Development, 12*(7), 6859–6872. https://doi.org/10.18697/ajfand.55.11606

Adhikari, R., Paudel, Y. R., & Pant, P. R. (2022). Food taboos and superstitions in child feeding: A systematic review. *Maternal & Child Nutrition, 18*(2), e13288. https://doi.org/10.1111/mcn.13288

Afolabi, W. A., Onabanjo, O. O., & Ijarotimi, O. S. (2017). Nutrition education intervention using culturally appropriate materials improved caregivers' feeding practices in Nigeria. *Journal of Nutrition Education and Behavior, 49*(2), 109–117. https://doi.org/10.1016/j.jneb.2016.10.004

Aikins, A. D. G. (1994). Food beliefs and taboos in Ghana: Their effect on child nutrition. *Journal of Ethnobiology, 14*(1), 27–40.

DOI: https://doi.org/10.5281/zenodo.17701466

Aunger, R. (1994). Are food avoidances maladaptive in the Ituri forest of Zaire? *Journal of Anthropological Research, 50*(3), 277–310.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Demissie, T., & Mekonnen, Y. (2019). The effect of cultural food taboos on child nutrition in Ethiopia. *BMC Nutrition, 5*(1), 1–8. https://doi.org/10.1186/s40795-019-0272-5

Ekwochi, U., Osuorah, D. I. C., Ndu, I. K., Ifediora, C., Asinobi, I. N., & Eke, C. B. (2016). Food taboos and myths in South Eastern Nigeria: The belief and practice of mothers in the region. *Journal of Ethnobiology and Ethnomedicine, 12*(1), 1–6. https://doi.org/10.1186/s13002-016-0102-7

Fischler, C. (2011). Commensality, society and culture. *Social Science Information, 50*(3–4), 528–548. https://doi.org/10.1177/0539018411413963

Ibrahim, M. S., Okafor, C. B., & Musa, A. (2021). Cultural influences on infant and young child feeding in Nigeria: A qualitative study. *International Journal of Maternal and Child Health, 9*(2), 45–56.

Kimani-Murage, E. W., Wekesah, F., Wanjohi, M., Kyobutungi, C., Ezeh, A. C., Musoke, R. N., & Griffiths, P. (2015). Factors affecting actualization of the WHO breastfeeding recommendations in urban poor settings in Kenya. *Maternal & Child Nutrition, 11*(3), 314–332. https://doi.org/10.1111/mcn.12161

Kitanaka, J. (2018). Superstitions and cultural health beliefs in Japan: An anthropological perspective. *Japanese Journal of Cultural Anthropology, 83*(2), 233–248.

Meyer-Rochow, V. B. (2009). Food taboos: Their origins and purposes. *Journal of Ethnobiology and Ethnomedicine, 5*(1), 18. https://doi.org/10.1186/1746-4269-5-18

NDHS. (2018). Nigeria demographic and health survey 2018. National Population Commission (NPC) [Nigeria] and ICF.

Ogundari, K., & Aromolaran, A. B. (2017). Impact of household income and education on child malnutrition in Nigeria. *African Journal of Economic Policy, 24*(2), 45–67.

Ogunsote, B. O., & Owoeye, A. O. (2023). Superstitious beliefs and food taboos in Nigerian communities: Implications for child nutrition. *Journal of Public Health in Africa, 14*(1), 137–146. https://doi.org/10.4081/jphia.2023.2184

Olukoya, A. A., Omilabu, S. A., & Adeyemi, M. (2006). Food taboos and myths in Nigeria: Their impact on child health and nutrition. *African Journal of Reproductive Health, 10*(3), 112–116. https://doi.org/10.2307/30032488

Oniang'o, R., & Komokoti, A. (1999). Food habits in Kenya: The need for culture-sensitive nutrition education. *African Journal of Food, Agriculture, Nutrition and Development, 4*(1), 25–33.

Pelto, G., Armar-Klemesu, M., & Siekmann, J. (2003). Food beliefs and taboos in child nutrition: The need for culturally appropriate interventions. *Public Health Nutrition, 6*(8), 759–766. https://doi.org/10.1079/PHN2003508

Rosenstock, I. M. (1974). The health belief model and preventive health behavior. *Health Education Monographs, 2*(4), 354–386. https://doi.org/10.1177/109019817400200405

UNICEF. (2021). *The state of the world's children 2021: On my mind – Promoting, protecting and caring for children's mental health*. UNICEF.

UNICEF. (2024). *Malnutrition and child survival: Global update*. UNICEF. https://www.unicef.org/reports

DOI: https://doi.org/10.5281/zenodo.17701466

World Health Organization. (2006). *WHO child growth standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age*. WHO.

World Health Organization. (2023). *Global report on the state of child nutrition*. WHO. https://www.who.int/publications

DOI: https://doi.org/10.5281/zenodo.17701466