



THE LIMIT OF CHANGE: CONTRADICTIONS ON NUTRITIONAL BEHAVIOUR BETWEEN PREGNANT WOMEN AND HEALTH CARE PROVIDERS IN OYO STATE, NIGERIA

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ABSTRACT

Nutritional Behaviour of pregnant women is in response to food intake beliefs, food handling practices, health related nutritional practices and access to nutritional information irrespective of nutritional health policies. While studies exist on nutritional behaviour with focus on food intake beliefs there is empirical gap on contradictions between health care providers and pregnant women nutritional behaviour. This study thus, examined the socio-cultural context of these contradictions among Yoruba ethnic populace in Oyo State, Nigeria. The study was cross-sectional and retrospective, adopting a qualitative method of data collection. In-depth Interviews and Focus Group Discussions were conducted with postpartum women, their significant others, community members and health care providers. Multi stage sampling technique was adopted in the selection of study area and population. Thematic and content analyses were used to analyse the qualitative data. Household structure, kinship system, social network, belief systems, marriage patterns and pathways to care influenced nutritional behaviour during gestation. Nutritional information accessed during antenatal visits contradicts nutritional behaviour of women during gestation. Teachings of the healthcare providers didn't have effect on their nutritional behaviour as this was immersed in socio-cultural factors. Nutritional policies targeted at improving pregnancy outcomes should recognise and integrate socio-cultural context of nutritional behaviour.

Keywords: *pregnant women, postpartum women, health care providers, nutritional behaviour, gestation period, the Yoruba*

BACKGROUND TO THE STUDY

Women's nutritional behaviour remains a global issue, with common problems and constraints that can only be resolved if women's health and nutrition are put in the context of the life cycle. It is a public health concern because poor nutritional behaviour can lead to a range of health problems for the mother and the growing foetus. In most developing countries one out of six infants are born with low birth weight. This is a risk factor for neonatal deaths, mental retardation, poor health and blindness (Oteng-Ntim, Varma, Croker, Poston and Doyle 2012; WHO, 2009).

The plight of the infants in most cases begins before their delivery with a malnourished mother. This has necessitated the World Health Organization to view child health in terms of "maternal-newborn health" in which the health of mothers is inseparable from the health of newborns (WHO, 2009). The burden of maternal death and infant mortality led to the National Integrated Maternal, Newborn and Child Health Strategy (IMNCH) in 2007. Generally there is poor coordination of programs and activities on Maternal Newborn Child Health (MNCH) which are inclusive of poor staffing and inadequate capacity building. Results from the National Demographic Health Survey (NDHS) 2013 show that infant mortality was 31 deaths per 1, 000 live births while maternal mortality ratio during the seven year period prior to the survey was 546 maternal deaths per 100,000 live births. Antenatal Care (ANC) serves as an opportunity to enlighten pregnant women to make informed choices which would result in good pregnancy outcome. Information, Education



and Communication (IEC) during antenatal care is strategized to educate women on how to make informed choices as regards their health status. Such informed choices are not limited to nutrition, hygiene, maternal and child care, breast feeding, immunization and family planning. Studies have documented the essence of health education in creating appropriate awareness which would improve the behaviour positively during gestation period (Sabine, et. al., 2013). Regular ANC is expected to build relationships and communication between pregnant women and health care providers which would result in reducing complications during pregnancy. However, in the sub-Saharan Africa, the health care providers are overwhelmed with the number of antenatal attendees. This invariable has implication on the service delivery (Agus and Horiuchi, 2012).

Nutritional behaviour which entails food intake belief, food handling practices, health related nutritional practices and access to nutritional information by individual is a socialization process. A process infused by the social and cultural environment. Women are at a disadvantage due to their access to education and economic opportunities. Their low level of education denies them access to nutritional information. Also the poor economic capacity and gender power relations deny women access to appropriate nutrition intake as household resource allocation may not be to their advantage most of the time (Ajiboye & Adebayo, 2012).

Earlier studies (Akeredolu, et al, 2014; Khoushabi and Saraswathi, 2010; Ramakrishnan, 2004) conducted on nutritional behaviour of pregnant women during gestation only focused on their food intake. Other indices such as food handling practices, health related nutritional practices and access to nutritional information have not being articulated into the social phenomenon of nutritional behaviour. Hence there is the need for a holistic study on the socio-cultural context of nutritional behaviour of pregnant women. In addition to this are contradictions on expected nutritional behaviour between pregnant women and health care providers among Yoruba ethnic populace in Oyo State, Nigeria.

METHODS AND MATERIALS

The study was retrospective and cross-sectional. It utilized a descriptive and explanatory research design. It was retrospective because it documented past experiences through interviews and discussions. Four Local Government Areas (LGAs) were randomly selected in Oyo State namely: Lagelu, Ibarapa Central, Ogbomosho North and Ibadan South East. The purposive selection of Oyo State was informed by its high maternal mortality rates (545 per 1,300 live birth) and neonatal mortality rates (37 per 8,900 live births) rates in South-western Nigeria (FMoH, 2011). Oyo State is homogenous mainly inhabited by the Yoruba ethnic group who are primarily agrarian but have predilection for living in high density urban centres. Like all other Yorubas, they claim descent from *Oduduwa*. They are rich in culture and have strong paternal family lineage with kinship ties as means of holding the society together. They are guided by an unwritten constitution cutting across all sphere of the individual's life. Rules of life and conduct are most times embedded in their culture such as prayers, proverbs, wise sayings and taboos. The study population entailed women who just gave birth and are yet to be discharged from the selected antenatal facilities (postpartum women), their significant others; health care givers; and community members. The respondents are of Yoruba descent. Informed consent of the respondents was sought and the purpose of the study was explained to the respondents. Information provided by the respondents was treated with confidentiality and respondents' anonymity was maintained. A total of twenty-four IDIs were conducted which entailed eight IDIs with postpartum women, four IDIs with health caregivers, six IDIs with postpartum women significant others, six IDIs with Community members. In



addition, eight FGDs (four each in the selected LGAs) were conducted with the community members. The interviews and discussion sessions were recorded using digital audio recorders. Content and thematic analyses was used to analyze the qualitative data.

FINDINGS

Knowledge of Respondents on Nutritional Behaviour

Findings from the qualitative survey revealed that the sole emphasis of respondents' knowledge about nutritional behaviour during gestation period was strictly on food intake. Other indices such as food handling practices, health related nutritional practices and access to nutritional information were not mentioned. The general knowledge of respondents' on this basically was on the kind of food a pregnant woman should eat to enhance good pregnancy outcome. Below is an excerpt from the qualitative data:

It is the food a woman eats when she is pregnant. Food that will have nutrients which will make the baby to grow well. (IDI, Postpartum woman, 32 years old, Ibadan South East)

Also, the health care providers interviewed made similar statement on their knowledge of nutritional behaviour of a pregnant woman which was strictly in relation to food intake. Below is a quotation:

The nutritional behaviour of the pregnant woman is the way they eat, the type of meal they eat regularly during their gestation period, that nine month of pregnancy, how they carry on their food plan and dietary..... for me it is only food the way they prepare the food and the type of food they eat (IDI, Orthodox Health Caregiver, 45 years old, Ogbomoso North)

Respondents' knowledge on other indices constituting nutritional behaviour of a pregnant woman such as access to nutritional information was probed. The response documented highlighted how nutritional behaviour is influenced through kinship ties and household structure which serves as a medium of communication in the dissemination of knowledge. Below is an excerpt from a community member.

When a woman is pregnant her parent-in-laws are happy. They will give her herbal medication and tell her that she will use it to take her bath and the one she will drink. Also the food she should eat, because the life of the pregnant woman is in the hands of her mother-in-law. They will educate her on the different types of herbal medicine so that nothing will happen to the unborn child and also there won't be much bleeding during delivery. The father-in-law is responsible for all the payments. Both couples her inexperienced so it's the duty of the parents in-law to educate the new couple (IDI, Female Elderly Community Member, 61 years old, Lagelu LGA)

Health care givers did attest to respondents' knowledge on nutritional behaviour through the influence of their access to nutritional information. Such influences are informed by their communication networks.



If they have relationship with their mother-in-law, it will influence the pregnancy outcome. Because everything the mother in-law says they will do, they will take to their advice. For example some of them will say this is the "agbo" I say you should be drinking. At times, you will see that in present time many of the pregnant women who really drink agbo, deliver, the life cord of their baby will be like the colour of the "agbo" they have been drinking. (IDI, Female 40 years old, Health care giver, Ibadan South East.)

On this premise, the health care providers' knowledge on access to nutritional information through kinship ties influencing nutritional behaviour was stated to be injurious to the well being of the pregnant woman and the unborn child. Such is the use of herbal medication like "agbo". "Agbo" is the traditional name for a variety of herbs and concoctions. An alternative medicine used by most Nigerians especially the native Yoruba people. According to one of the interviewed health care provider, she said thus on the use of agbo: "yes it is very bad, it can kill the baby, some babies we will deliver them suffocating". Despite health talk given by the health care providers to these women to refrain from the use of herbal concoctions, some of the women are said to adhere strictly to its usage.

Respondents' nutritional behaviour during gestation period

Findings from the study on respondents' nutritional behaviour during their gestation period, in response to food intake belief revealed a lot. For instance among indigenes of Igbo-Ora in Ibarapa Central their cultural belief in a particular meal called "llasa" which is said to improve their fecundity was well documented. The indigenes referenced their fecundity of multiple births to "llasa" which is a soup prepared with the Okoro Leaves and can be taken with solid meal like Amala. The food intake of this meal according to the respondents had been scientifically proven for its potency for multiple births. This suggests that the type of food eaten by women had effect on their reproductive system. Below is a quotation from one of the interviewee:

Also what we eat is different to what others are eating. Whoever comes into Igbo-Ora, when the person eats llasa, the person will know that the soup is good and it gives one good strength. And we like Amala White with it that is the reason why we do have twins. (IDI, Postpartum mother, 24 years old, Ibarapa Central)

The belief of "llasa" when it is eaten frequently resulting into multiple births was also verified by the community members:

I would say that God works in a mysterious way. Firstly, having twins in Igbo-Ora has been destined by God also I would say what we eat in this side of Ibarapa, in Igbo- Ora is different from other Ibarapa communities. Firstly I would say we eat a soup called "lla". It is the leaf of this lla that we call "llasa". (IDI, Male Elderly community member, 63 years old, Ibarapa Central).

Aside from the cultural influence of eating a specific type of meal, some foods were actually forbidden to be eaten by pregnant women. Some of these foods were not eaten by these expectant mothers cause of the cultural belief and fear of the consequences if they eat these foods. Below are excerpts from the respondents who mentioned that they did not eat these tabooed food.



I did not eat eba, meat and pounded yam because I did not want my child to be heavy. I did not eat snail so that my child won't be salivating. Even grasscutter, so that my child won't be stealing. (IDI Postpartum woman, 26 years old, Ogbomosho North)

Though I can't talk of a particular food taboo. Although when you talk about ogede agbagba (banana) I did not eat it because it causes "oka ori" (frontal lobita), thus I did not eat it during my gestation period. (IDI Postpartum woman, 29 years old, Lagelu).

Similar statement was reiterated in the FGD session:

I use to eat egg before I got pregnant, but when I got pregnant I stopped eating egg and plantain. (FGD, Young female, Ogbomosho North)

However, some of the respondents mentioned they ate these forbidden foods and they never experienced any of the consequences caused by not adhering to the food taboos.

I ate plenty of plantain and my child did not have oka ori (fontanel). (FGD, Young female, Ogbomosho North)

Like snail, we are always told at the hospital to eat it cause it is good and others will say one must not eat it cause it will make the child to salivate, I ate snail and my child did not salivate, nothing happened to my child. (FGD, Young female, Ibadan South East.)

The nutritional behaviour of women adhering to food taboos during their gestation period was iterated by the health care providers.

I can say that these women do adhere to these food taboos, let say about 40% of these women who come for antenatal. (IDI, Female 40 years old, Health care provider, Ibadan South East)

Other documented findings from the study on the health related nutritional practices of these women were when they came to register for antenatal. In addition, there were variations in the type of health care they sought such as the traditional birth attendants and the faith based health care. Below are excerpts from the data indicating when antenatal care commenced:

I registered for antenatal when I was four months into my pregnancy. (IDI, Postpartum woman, 24 years old, Ibarapa Central,).

I always drink herbal medication. Whenever I have fever I use the herbal medication. But when my pregnancy was 6 months and some weeks old, I went to the hospital (IDI, Postpartum woman 28 years old, Lagelu LGA)



According to the health care providers, it was observed that some of these women do not come for antenatal care on time.

I can rate it as low, the reason is because if it is not up to twenty-four weeks some women will not come to the clinic and is not supposed to be like that as early as twelve weeks a woman is supposed to report for antenatal to come and take counselling, treatment and any other thing that need to be done during their gestational period. So they need to come early and regularly during their gestation period. (IDI, Female Health care provider, 45 years old, Ogbomosho North)

Furtherance on respondents' nutritional behaviour is their access to nutritional information which informed their nutritional behaviour. Some of the respondents indicated they got nutritional information during their antenatal visits. However, some other respondents stated they were not well informed by the health care providers on expected nutritional behaviour. Despite respondents' statements on their enlightenment about expected nutritional behaviour of a pregnant woman during antenatal visits, some still adhered strictly to the various food taboos. This act of nutritional behaviour was stated to have been influenced by their parents, parents-in-laws and spouses. The nutritional information received from these aforementioned persons contradicts that received during their antenatal visits. Below is an excerpt from a respondent:

My mother-in-law was there too advice me on what to eat and what I should not eat. Though some of what she told me not to eat I was told I can eat at the antenatal clinic. (IDI Postpartum woman, 32 years old, Ibadan South East)

Generally, it has been established from this research findings that there are kinship ties informing the nutritional behaviour of women during their gestation period. Household decision plays a prominent role in informing the nutritional behaviour of women. Often times with the socialization process of an individual within the African context, an individual is meant to be submissive to some category of people based on their status and role. It is believed that they are more experienced and knowledgeable on situations and it would be advisable for an individual to heed their instructions and advice. Some of this influence has to do with the household structure and kinship ties. Below is an excerpt from a respondent:

Pregnant women who have good parents will instruct her on what to eat and how to behave during pregnancy such as the way she must sleep, not to walk in the middle of the night, not to walk in the mid afternoon. And if the pregnant woman adheres to these instructions of the elderly who have seen, there won't be any problem for her during her pregnancy. (IDI, Male Elderly community member, 63 years old, Ibarapa Central)

Even the health care providers attested to the influence of kinship ties on the nutritional behaviour of women during their gestation period. The health care providers do educate them when they come for antenatal. However, there are shortcomings in the nutritional behaviour of these women which invariable is said to have been influenced by the culture of the said persons. These behaviours contradict the teachings of the health care providers.



Of course when these women come for their antenatal we make efforts to educate them most especially on foods which we have observed over time that they don't eat. They claim that if they eat these foods there are consequences. Such as when they don't eat snail because they believe their child when born will be salivating profusely. These should be expected, a baby will salivate but not as a result of the snail that was eaten during pregnancy. Snail has rich nutritional value but it is tabooed not to be eaten. There is the belief and respect for culture which should not be violated. (IDI, Female 40 years old, Health care giver, Ibadan South East)

Socio-cultural factors influencing nutritional behaviour

Pregnant women are known to display different kinds of nutritional behaviour during their gestation period and culture is said to be an influencing factor. From the analyses of data obtained from the study, culture was observed to play a prominent role informing knowledge, attitude and their nutritional behaviour. For instance, taboos are affiliated to one's lineage which has kinship ties.

In Yoruba land, each household has its cultural tradition which the woman who is coming into the household must adhere to cause the child she gives birth to belong to the man. If it so happens that the husband family are Muslim, or they worship Sango or masquerade worshippers, she must equally follow suit because a woman has no religion, whatever the husband does she must do. (FGD, Adult Male Community Member, Ibadan South East)

In some instances, these lineage affiliation has implication on the nutritional behaviour of a pregnant woman. It could be said that some foods are forbidden to be eaten in a particular lineage.

Different lineages have their food taboos. But now the whites have made life more comfortable. But then there are some people that when they are pregnant there are some foods that are forbidden, and they are warned on this. For instance, a pregnant woman must not eat egg. (IDI, Female Community Member, 51 years old, Lagelu LGA)

With the influx of westernization, some of the respondent's orientations are changing regarding food taboos.

In the ancient times, our forefathers have believed in these food taboos. But now is the time of civilization, it's only if you want to believe in those taboos that it will happen to one. (FGD, Young Women, Ogbomosho North)

They say a whole lot of things that the pregnant woman should not eat. But if you eat in front of the elderly people something will happen if one believes in it. (FGD, Young Women, Ogbomosho North)



However, there are contrary opinions and experiences among the respondents on what they believe or do not believe as regards food taboos. Below is an excerpt from the analyzed data:

I have a friend whose husband lineage forbids the eaten of "Okete"(Rodent) because it will make the child to steal. But my friend ate it and did not let her husband's people know. The child is six years now and doing okay maybe if she had told them they would have said a prayer on her and her child won't turn out well because of what she ate (FGD, Young Women, Ogbomosho North)

Basically, culture is said to play a prominent role in informing the nutritional behaviour of women during their gestation period. These influences take cue from their belief systems, house hold structure and even kinship ties. A crucial factor is socialization which is a lifelong process in which social and cultural continuity is attained and sustained. This is achieved through inculcating the norms, customs, values and ideologies of a society which are passed on from one generation to the next. The Yoruba culture is not an exception on this; they have strong norms and values which invariably influences the nutritional behaviour of a pregnant woman. These norms and values are binding on the ethnic population. Below is a quotation on this:

Our mothers make it mandatory for the pregnant women to adhere to these rules, because that's how we met it (IDI, Postpartum woman 33 years old, Ogbomosho North)

Similar findings were also observed in the FGDs of the influence of spouses on the nutritional behaviour of pregnant women.

What I want to say is when one is pregnant one need to listen to her husband. One's husband can say go to the hospital. Whatever one's husband says one should follow. He could say go to the church. Whatever one's husband wants that's what the pregnant woman should do (FGD, Young women, Ogbomosho North).

To the in laws and parents, their belief is they are advising the expectant mother appropriately and this is from their own experience.

I can also decide for my daughter and her husband as his mother in law. Because I will tell him that these were the things I eat when I was pregnant with his wife's pregnancy. (IDI, Adult Significant Mother 57 years old, Lagelu)

These women have strong belief that if they adhere to the instructions of their spouses, in-laws or parents, they will have a safe delivery.

It is believed that if ones husband, parents or in-laws instruct a pregnant woman on how to behave and she heeds she would have a safe delivery. (FGD, Adult Women, Ibadan South East)

It's always good to listen to one's husband. I have a friend whose husband told her to go to the hospital but she insisted on the traditional birth attendant. When she was about to give birth they took her to the TBA, the child's head came out, but the whole body did not so she was



taken to the hospital where she was eventually operated on. You see now why it is good to listen to one's husband. (IDI, Postpartum woman 19 years old, Ibarapa Central)

It was observed that the health seeking behaviour of a pregnant woman is influenced by the household decisions in that family. Such decisions could be made by their husbands or mother-in-laws

The household decisions on pregnant women are made by their husbands. Because where ever the woman goes the man is fully responsible. (IDI, Postpartum woman 37 years old, Ogbomosho North)

Our mother-in-law also advise us on where to go when we are pregnant. (IDI, Postpartum woman 24 years old, Ibadan South East)

In some instances, you see some pregnant women going for herbal care.

In the olden days, when a woman is confirmed to be pregnant from one or two months she will start taking herbal medication. The herbal medication will be cooked very hot. She will be given this medication to drink and to take her bath during her gestation period. Another herbal medication will be prepared for the woman which she will drink on the day she is to put to bed for safe delivery. These are the things that were used for pregnant women which we had belief in, in the olden days.

IDI, Postpartum woman 37 years old, Ogbomosho North)

Some do go to churches when they are pregnant:

We don't take herbal medicine we go for night vigil, they will give us holy water that we will drink. (FGD, Adult Female, Lagelu LGA)

The holy water is a miracle water cause what we don't see the water will help heal. (IDI, Adult female, 36 years old, Ogbomosho North)

The strong hold of culture on these women informing their nutritional behaviour mentioned by the health care providers is the yielding to the demands of their in-laws and parents as well as their spouses despite the teachings at the antenatal centres. Find below excerpts from the health care providers:

Sometimes the husband may not have any say in it because of their parents. They will say that what their parents have said is final. They don't have anything to say again. (IDI, Female 43 years old, Health caregiver, Lagelu LGA)

We do try our best by educating these women. However we have realised that culture is very strong not to talk of an ethnic group such as the Yoruba who have reverence for their elders as well as respect for culture. You know there is this belief that if you go contrary to the norm there are terrible consequences for such acts. Will just have to put in



*more efforts to enlighten those involved like the parents and in-laws.
That is why we do encourage them to follow these women for antenatal
(IDI, female 47 year old Health caregiver, Ibadan South East)*

DISCUSSION

A major finding of this study is that respondents have limited knowledge of nutritional behaviour. The study found that the level of knowledge of the respondents on appropriate nutritional behaviour was inclined mainly on food intake. Nutritional behaviour generally entails food intake belief, food handling practices, health related nutritional practices and access to nutritional information. However, respondents construed nutritional behaviour only as food intake belief. Statement of fact which was equally corroborated by the health care providers. Similar finding was also indicated in earlier studies where focus of nutritional behaviour had strictly been on food intake only (Fallah et al., 2013; Mirsanjari et al, 2012; Bawadia et al, 2010; Isreal et al, 2005).

Respondents' sources of nutritional knowledge on expected nutritional behaviour varied. The various sources mentioned by the respondents ranged from families (most especially spouses and parents in-laws) to health care providers. Only a few of the respondents indicated the media (specifically radio). These sources of information on knowledge of expected nutritional behaviour was tuned towards food intake belief as mentioned earlier. Earlier studies in the developed world have shown that respondents' main source of knowledge which often times inform their nutritional behaviour are in three categories. These are mass media most especially the internet, social environment (sharing of ideas and experience with other women) and health care providers (Szwajcer et. al. 2005). In sub-Saharan Africa, such as in rural Kenya, Van Eijk et al, (2006) in their study which was conducted among women who attended antenatal clinics prior to delivery observed that 11% of these women were receptive to health information provided by the health professionals.

A similar observation was seen among rural Nigerian women who identified midwives and nurses as their major source of health information on maternal and child health (Akin-Otiko and Bhengu, 2012). It should be pointed out that based on benefit of hindsight from these earlier studies, a comparative study was conducted between women who attended ANC and those who never did in rural Kenya. This was done to investigate if there was disparity in their nutritional behaviour during gestation based on their level and source of information on nutritional knowledge. The findings revealed that higher number of ANC clinic visits and higher maternal education level were significantly positively associated with maternal health knowledge (Perumal et al., 2013).

However, according to Verbeke and De Bourdeaudhuij (2007), the high knowledge of food intake among expectant mothers is not an indicator that would make them change their nutritional habits. Similar observation on this was seen in the qualitative data where respondents did not adhere strictly to information received during antenatal on food intake due to inculcated food taboos. The health care providers indicated that despite their teachings on nutritional education, some of the respondents during their gestation period still abide by the food taboos. Basically, the purpose of health education is to eliminate undesirable behaviours and replace them by appropriate and productive behaviour leading to a healthy life (Perez-Escamilla et al., 2008).

For some of the respondents who did not adhere to the food taboos they testified to the consequences of refraining from the norms such as the child who is born with an abnormal fontanel "*oka ori*" due to the fact that the expectant mother ate plantain; excessive salivating due to eating of snails; delay in the child not walking on time due to eating of snake. Similarly, in the developed nations it was observed that pregnant women do not adhere to the nutritional



guidelines. This observation was seen among pregnant women enrolled into New Zealand's new birth cohort study. Most pregnant women in New Zealand do not adhere to nutritional guidelines in pregnancy, with only 3% meeting the recommendations for all four food groups. Adherence varies more so with ethnicity than with other socio-demographic characteristics (Morton, et al., 2014).

Use of herbal medication among pregnant women in Nigerian communities have been said to have toxicity, teratogenic potentials and associated feto-maternal complications by the health care practitioners (Bamidele, Adebimpe and Oladele, 2009). In this current study, the health care providers posited that the use of herbal remedies by women during their gestation period have harmful effect on the foetus. It was further mentioned that some children are born with their umbilical cord being discoloured which is not healthy.

Respondents made mention that they did not have access to nutritional information. For instance, findings of the qualitative data revealed that the population of expectant mothers attending antenatal at the PHC is large. Thus, according to the health care providers less time is dedicated to health talk since there is more to be done on medical check-up (weight, blood pressure etc) for these women. More time is spent on praying and singing. Such is expected in a country like Nigeria that has belief in superstition. Furthermore, this health care centres are under staff.

Shortcomings of the Primary Health Care providers were observed in the developed nations from the review of literature which spanned through the period of 2002 and 2014. The health care providers did perceive the importance of health education during antenatal. However, lack of time, resources and relevant training on nutrition education hindered proper dissemination of information to these expectant women (Lucas, Charlton and Yeatman 2014; Lavender and Smith, 2015). Similar findings was observed in this study, however aside the fact that the PHCs are short staffed, the health care providers stated and emphasized on the effect of culture on the nutritional behaviour of pregnant women. They try as much as they can to enlighten these women on the expected nutritional behaviour. Over the years in their practice of antenatal care, it was observed that pregnant woman do adhere strictly to their held beliefs which serve as a norm informing and guiding their nutritional behaviour. Thus, contradictions on expected nutritional behaviour between the health care providers and pregnant women. These contradictions in the expected nutritional behaviour is said to extend to these women significant others like their parents, in-laws and spouses.

From a sociological perspective, for one to understand the nutritional behaviour of these respondents there is the need to understand their culture and social interaction. The culture of people is what best describes the group. A group can be understood and described based on its cultural practices, because culture best explains why and how they do what they do and behave the way they behaved.

CONCLUSION

A clear starting point in tackling contradictions on nutritional behaviour between health care providers and pregnant women will be through coordinated, long term efforts on educative programs. Patriarchal structure of the society restrains women's freedom and decision making. These subjugating norms and values need to be re-addressed. It is important that public health intervention section of ministries of health should initiate Attitudinal and Behavioural Changes (ABC) among men and other members of the society to address general cultures values. Health care providers should see the antenatal period as an avenue for change among these women through communication. In some areas one important task of nutrition education is to persuade people to abandon food taboos and customs that contribute to malnutrition among pregnant



women. Getting rid of these practices requires more than just handing out information to women obviously. Traditional leaders and the entire community need to have information that will persuade them that there is no foundation for the superstitions. This will aid in improving maternal health and reducing infant morbidity in the developing nations.

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