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**THE INFLUENCE OF CULTURAL FACTORS TOWARD MALNUTRITION  
PREVALENCE AMONG CHILDREN UNDER FIVE YEARS OLD IN MBARALI  
DISTRICT, TANZANIA**

**<sup>1</sup>Magdalena Ngenzi, <sup>2</sup> Given M. Msomba <sup>3</sup>Frank Philipo**

Department of Community Development, Faculty of Arts and Social Sciences,  
University of Iringa, P.O Box 200, Iringa-Tanzania.

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\*Corresponding Author: **<sup>1</sup>Magdalena Ngenzi**

Department of Community Development, University of Iringa,  
Tanzania.

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### **Abstract**

Malnutrition among children under five remains a critical public health challenge globally, particularly in low- and middle-income countries, including Tanzania. This study investigated the economic, social and cultural determinants of malnutrition among children under five in Mbarali District, Mbeya Region. A mixed-methods cross-sectional design was employed, collecting quantitative data from 60 caregivers through structured questionnaires and qualitative data via five focus group discussions and 12 key informant interviews. Findings revealed that cultural factors, including food taboos, traditional beliefs and gendered caregiving roles, significantly influence child-feeding practices and dietary diversity, contributing to stunting and underweight. Inadequate meal frequency, limited paternal involvement and socio-economic constraints further exacerbate malnutrition. Additionally, community perceptions and stigma surrounding malnutrition were found to hinder timely healthcare-seeking and adoption of proper feeding practices. The study recommends that malnutrition in Mbarali District is a multifaceted issue rooted in economic hardship, social inequities and entrenched cultural norms. Integrated interventions that combine economic empowerment, nutrition education, culturally sensitive practices and enhanced paternal engagement are recommended to improve child nutritional outcomes.

**Keywords:** Malnutrition, under-five children, cultural factors, feeding practices, gender roles, Tanzania, socio-economic determinants..

## 1. Introduction

Globally, malnutrition continues to pose a major public health challenge, particularly in low- and middle-income countries. Recent data indicate that approximately 21.3% of children under five years of age experience stunting (low height-for-age), while 6.9% suffer from wasting (low weight-for-height) (UNICEF, 2020). Similarly, the World Health Organization (WHO, 2020) reported that around 149 million children under five are stunted and about 45 million are wasted worldwide. These conditions are strongly associated with poor dietary intake, limited healthcare access and socio-economic inequalities. Consequently, malnutrition remains disproportionately prevalent in low- and middle-income countries, reflecting the need for integrated public health interventions that enhance access to nutritious foods, healthcare services and socio-economic support systems. Addressing both undernutrition and overnutrition is essential to improving child health and overall well-being globally.

In Africa, malnutrition remains a critical concern, with Sub-Saharan Africa exhibiting the highest prevalence rates of childhood malnutrition. According to the World Health Organization (2023), nearly 40% of children in the region are stunted and a considerable number experience wasting. Countries such as Nigeria, Chad and Ethiopia record some of the highest stunting rates on the continent. The underlying causes include weak food systems, insufficient healthcare infrastructure and persistent poverty. Moreover, factors such as climate change, political instability and rapid urbanization further exacerbate food insecurity and nutritional deficiencies among young children in the region.

In Tanzania, malnutrition rates remain significantly high despite government and international interventions aimed at combating the problem. The Tanzania Demographic and Health Survey (TDHS, 2022) reported that 34% of children under five are stunted, while 5.8% experience wasting. Regional disparities are evident, with rural areas disproportionately affected compared to urban areas. The Mbeya Region, including Mbarali District, mirrors these national trends. According to Mrema et al. (2021), the stunting rate in Mbarali District is approximately 47.2%. The persistence of high malnutrition rates highlights the complex interplay of socio-economic, cultural and environmental factors. Poor child feeding practices, limited maternal education, cultural beliefs and financial constraints contribute significantly to inadequate nutrition among children in the district. Although food availability is relatively stable in Mbarali, children remain vulnerable to malnutrition due to insufficient awareness of proper feeding practices and reliance on nutrient-deficient diets. In addition, limited access to healthcare and inadequate maternal and child care exacerbates the issue. Therefore, this study investigates the specific determinants of malnutrition among children under five years of age in Mbarali District.

## Theoretical Framework

### 2. Literature Review

The Social Determinants of Health (SDH) theory is relevant to this study because it provides a comprehensive understanding of how social, economic and environmental factors influence children's nutritional outcomes in Mbarali District. According to the World Health Organization (2010), health is shaped not only by biological or genetic conditions but also by the circumstances in which individuals are born, grow, live, work and age. These determinants such as income, education, access to healthcare and living conditions collectively affect children's growth and development. In Mbarali District, socio-economic inequalities, including low household income and limited maternal education, hinder access to adequate nutrition and healthcare services, thereby increasing the risk of malnutrition among children under five years old. The SDH framework therefore explains how poverty and social disadvantage serve as root causes of poor health outcomes, emphasizing the importance of addressing structural inequities alongside individual behaviors (WHO, 2010).

Furthermore, the SDH theory clarifies the broader social and structural inequalities that perpetuate malnutrition even when food is generally available. As highlighted by Marmot and Wilkinson (2005), disparities in health often arise from unequal access to resources and opportunities within societies. In Mbarali District, cultural norms regarding child feeding, gender roles and limited women's empowerment contribute to inadequate nutrition among children. Environmental challenges such as poor sanitation, limited clean water and weak healthcare infrastructure further exacerbate these issues. Applying the SDH perspective enables this study to examine malnutrition within its broader socio-economic and cultural context, emphasizing the need for multisectoral interventions that promote nutrition education, poverty reduction and equitable healthcare access (Marmot and Wilkinson, 2005; WHO, 2010).

#### 2.1 Literature Review

Malnutrition among children under five years of age remains a persistent global health problem, particularly in developing regions such as Sub-Saharan Africa. The World Health Organization (WHO, 2020) reports that approximately 149 million children under five suffer from stunting and 45 million from wasting globally. These conditions result from an imbalance between nutrient intake and the body's needs, which are often influenced by a range of social and cultural determinants. In Tanzania, despite efforts to improve nutrition through various national programs, child malnutrition remains a public health challenge, with cultural factors playing a substantial role in shaping feeding behaviors, food choices and healthcare practices (Tanzania Demographic and Health Survey [TDHS], 2022).

Cultural beliefs and practices deeply influence dietary patterns and child-feeding behaviors within many African communities. According to Pelto and Armar-Klemesu (2011), culture dictates what foods are considered appropriate for infants and young children, affecting both

the type and quantity of food offered. In some Tanzanian communities, taboos restrict pregnant or lactating mothers from consuming protein-rich foods such as eggs, fish, or meat, which are believed to cause complications during childbirth. Such beliefs result in nutritional deficiencies for both mothers and children. Similarly, the introduction of complementary foods is often delayed due to traditional norms, leading to prolonged exclusive breastfeeding without sufficient nutrient supplementation (Lutter & Daelmans, 2020).

Gender roles within traditional societies also contribute significantly to malnutrition among children. As Mosha et al. (2021) observed, in many rural Tanzanian households, women bear the primary responsibility for food preparation and child feeding, yet their decision-making power regarding household resources is often limited. This lack of autonomy restricts women's ability to purchase or prepare nutritionally balanced meals. Additionally, when cultural norms prioritize men's dietary needs, women and children often consume less diverse and lower-quality diets. The unequal distribution of food within households thus exacerbates childhood malnutrition, especially in resource-constrained families (FAO, 2019).

Cultural perceptions surrounding health and illness also shape caregivers' responses to childhood malnutrition. Matunga et al. (2020) found that in several Tanzanian communities, malnutrition is not always recognized as a medical condition but may instead be attributed to spiritual or supernatural causes, such as witchcraft or ancestral displeasure. As a result, caregivers may delay seeking medical attention, opting instead for traditional healers. This delay contributes to worsening malnutrition and increased mortality among children under five. The persistence of such beliefs underscores the importance of integrating cultural understanding into community-based health education programs.

Furthermore, feeding practices rooted in cultural traditions often determine the timing and type of complementary foods provided to infants. Oniang'o, Mutuku and Malaba (2012) reported that in East African settings, many caregivers introduce thin cereal porridges early as the main complementary food, despite their low nutrient density. The reliance on starchy foods such as maize or cassava, with minimal protein and micronutrient content, leads to energy sufficiency but nutrient deficiency. In Mbarali District, where maize-based diets dominate, such feeding patterns are common and contribute significantly to stunting and wasting among children.

Another cultural factor influencing malnutrition is the perception of ideal child body size and health. In some Tanzanian communities, a plump child is perceived as healthy, while thinness is associated with illness or neglect. Mrema et al. (2021) noted that these perceptions can discourage caregivers from recognizing early signs of malnutrition, delaying corrective measures. Conversely, in other communities, excessive thinness is accepted as normal due to chronic poverty and food scarcity. These differing cultural perceptions affect parental motivation to seek nutritional guidance or medical intervention, thus perpetuating the cycle of malnutrition.

Maternal education plays an integral role in mediating the influence of cultural practices on child nutrition. Kamau-Thuita, Omwega and Muita (2014) demonstrated that educated mothers are more likely to adopt scientifically informed feeding practices and to challenge harmful cultural norms. In contrast, low literacy levels in rural areas, including Mbarali District, limit awareness of appropriate infant feeding and dietary diversity. Education empowers mothers to critically assess traditional beliefs, recognize symptoms of malnutrition and utilize available healthcare services (UNICEF, 2020). Thus, education acts as a cultural and social determinant of child nutrition outcomes.

The interaction between cultural norms and socio-economic status further complicates the nutritional landscape. According to Nguyen et al. (2018), poverty reinforces adherence to traditional practices by limiting access to alternative food choices. When households cannot afford diverse diets, cultural justifications often emerge to rationalize food scarcity, such as beliefs that certain foods are “not meant” for children or women. In Mbarali District, such economic and cultural constraints overlap, resulting in consistent reliance on low-cost, nutrient-poor foods. Addressing these intertwined factors requires both cultural sensitivity and economic empowerment strategies.

Health communication and community engagement approaches have proven effective in addressing cultural barriers to improved nutrition. Studies by Abuya et al. (2012) and Black et al. (2013) show that community-based nutrition programs that respect local traditions while promoting healthy practices achieve higher success rates. For instance, involving traditional leaders and community elders in nutrition education initiatives fosters acceptance and sustainability of behavior change. In Mbarali District, culturally tailored interventions that align nutrition messages with community values can significantly reduce malnutrition rates among children under five.

The study revealed that, cultural factors play a pivotal role in shaping child-feeding practices, health-seeking behavior and nutritional outcomes in Mbarali District and across Tanzania. The reviewed literature demonstrates that beliefs, traditions and gender norms influence the type and timing of food provision, as well as caregivers’ responses to child illness. While cultural practices are deeply rooted, they are not static and can evolve through targeted education and community participation. Therefore, understanding and integrating cultural dynamics into nutrition programs is essential for achieving lasting reductions in malnutrition among children under five in Mbarali District.

### **3. Research Methodology**

This chapter presents the methods and procedures employed to investigate the determinants of malnutrition among children under five years in Mbarali District, Mbeya Region. It describes the study area, research approach and design, target population, sampling procedures, data collection methods, data analysis and ethical considerations. The study was conducted in Mbarali District, one of the seven districts in Mbeya Region, located between latitudes 8°00' and 9°00' South and longitudes 33°00' and 34°00' East. The district covers approximately 14,438 square kilometers and has a population of 446,336 people (URT,

2022). Mbarali was chosen due to its high rates of child malnutrition, with stunting and underweight prevalence exceeding the national averages, as reported by the Tanzania Demographic and Health Survey (TDHS, 2022) and Mbarali District Council (2023). The study area's heavy reliance on subsistence agriculture, persistent food insecurity, low maternal education and limited access to healthcare services make it a suitable location for examining the determinants of child malnutrition.

The study adopted a mixed-methods approach, integrating both quantitative and qualitative methods to obtain comprehensive insights. Quantitative data were gathered through structured questionnaires administered to 60 caregivers, parents and guardians of children under five, selected randomly across five wards Mahongole, Ubaruku, Ipwani, Ruiwa and Rujewa. The sample size was determined using Yamane's formula with a 7.8% margin of error from an eligible population of 12,450 caregivers (Mbarali District Health Report, 2022). Qualitative data were obtained from 12 key informants selected purposively, including community health officers, nutritionists, clinical officers and community development officers. The combination of these methods ensured data triangulation, enabling the study to explore not only statistical patterns but also the underlying social and cultural factors influencing malnutrition. A cross-sectional research design was employed, allowing data to be collected at a single point in time to determine relationships between socio-economic, cultural and health factors and malnutrition among children under five.

Primary data collection methods included structured questionnaires for quantitative data and focus group discussions (FGDs) and key informant interviews (KIIs) for qualitative insights. Five FGDs, each comprising 8–10 parents or caregivers, were conducted one per ward to explore community beliefs and practices related to child nutrition and health. KIIs were conducted using semi-structured guides to collect expert opinions on determinants of malnutrition. Secondary data were also reviewed from government health reports, HMIS records, academic journals and NGO assessments to provide contextual background, historical trends and policy frameworks on malnutrition in the district. Quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 27, where descriptive statistics such as frequencies and percentages were computed. Qualitative data were analyzed using content analysis, organizing responses into themes aligned with the study objectives to interpret recurring ideas and patterns.

To ensure validity and reliability, research instruments were reviewed by academic supervisors and field experts and a pilot study was conducted to test clarity and consistency before the main data collection. Reliability was strengthened by explaining the study's purpose clearly to participants, using simple language and maintaining neutrality during interviews to minimize bias. Ethical considerations were strictly observed throughout the study. Formal permission was obtained from Mbarali District authorities and ethical clearance was granted by the University of Iringa. Informed consent was secured from all participants after explaining the study's objectives, voluntary participation and confidentiality assurances. Participants were informed of their right to withdraw at any time without

repercussions, ensuring adherence to ethical standards for research involving human participants.

#### 4. Findings and Discussion

The study describes the cultural factors that bear on the prevalence of malnutrition among under-five children. It addressed how culture impacts household behavior including taboos and more traditional beliefs, feeding practices and gender roles and how the community perceives malnutrition. The findings were disaggregated based on the mentioned indicators as shown in the subsection below

##### 4.1 Existence of taboos and traditional beliefs in the study area

Taboos and traditional beliefs in the study area were observed that most (60%) of respondents confirmed the existence of cultural or traditional restrictions in the community, while 40% reported no such restrictions (Table 11). Additionally, 65% of respondents indicated that traditional beliefs affect how children are fed, compared to 35% who said they do not. The findings of the study found that the majority of participants (65%) mentioned that traditional beliefs have an effect on child feeding practices. It was shown that there are particular nutrient rich types of food such as eggs, meat and milk, which are sometimes forbidden due to the impact of cultural values, thus resulting into incomplete food consumption and increasing susceptibility to malnutrition in children. The study highlights the fact that food taboos and feasting practices which are culturally mediated are important barriers to satisfactory child nutrition. In most cases, communities avoid provision of some healthy foods to children because they misjudge health impacts, development consequences and religious beliefs.

**Table 11 Existence of food traditional beliefs in the study area (n=60)**

Responses	Frequency	Percent (%)
<b>Presence of food traditional restrictions your community</b>		
Yes	36	60
No	24	40
<b>Traditional food restriction children feeding</b>		
Yes	39	65
No	21	35

**Source:** *Field Data*, (2025)

The result of the study shows that taboos and traditional belief in the study area undermined the health status of the many children. Whereas, parents inhibited to feed children some categories of food by stating that that type of food may lead to fatness of the children. Among the food that are most inhibited to be fed to children as indicated in this study were eggs, bananas and other rich protein food. The result of the study show that the study area is mostly hindered with negative traditional beliefs which explore the health of the children by not given enough food to eat. The study shows some of respondent were giving a nutritious food, but most of them giving in low amount with the same perception of avoiding fatness to their children. During FGDs conducted in Ipwani Ward, one discussant explained:

In our community, some foods are not given to children because of beliefs. For example, eggs are said to make a child steal when he grows up and meat is believed to cause teeth problems. Because of these beliefs, some mothers avoid giving these foods even when they can afford them” (FGD with caregivers and parents, Ipwani, 15/08/2025).

Another discussant added:

Even when health workers teach us about good feeding, some of us still fear what elders will say if we give children foods that are forbidden. We do not want to go against our traditions” (FGD with caregivers and parents, Ruiwa, 15/08/2025).

The findings of the study align with findings by Msuya and Shayo (2021), who recorded that food restrictions among traditional foods in communities had a negative influence on the dietary and nutritional status of children in Tanzania communities. Similarly, Mgina *et al.* (2020) noted that the beliefs on culture influenced consumption of rich protein and micronutrient rich foods, increasing susceptibility to stunting and under-weight among pre-school children. During interviews with key informants in Mbarali District, it was observed that cultural taboos and traditional beliefs significantly influence household feeding practices. Most respondents indicated that certain foods such as eggs, meat and milk are considered inappropriate for young children due to fear of negative consequences on health, physical development, or cultural prohibitions. These taboos were reported to reduce dietary diversity and increase children’s vulnerability to malnutrition. The findings of the study revealed that respondents acknowledged the presence of cultural or traditional restrictions and reported that these beliefs influenced child feeding practices. Qualitative evidence confirmed that certain nutrient foods, such as eggs, meat and milk, are often avoided due to cultural or religious prohibitions, even when families can afford them. Therefore, the findings of the study indicate that food taboos and traditional beliefs act as significant barriers to dietary diversity and adequate nutrition, increasing children’s susceptibility to malnutrition

#### 4.2 Feeding practice of respondents

The study findings as indicated in Table 12 show that 58.3% of households providing only 1-2 meals per day, 28.3% provided three meals and 13.3% offered more than three meals per day (Table 10). With regard to child feeding responsibility, 40% indicated that mothers were responsible, 5% reported fathers, 10% mentioned grandmothers, while 46.7% reported house girls. The findings of the study indicate that the inappropriateness of meal frequency is widespread, whereas the issue of child nutrition is mostly left vested in mothers and other female caretakers. The number of meals was low hence reducing caloric incursion and decreasing elements uptake and hence malnutrition seen as a possibility. The result of the study show that most children affected due to irregular meal frequency per day which is the result of the study area to have malnutrition.

**Table 12 Feeding practice of respondents and child wellbeing (n=60)**

Responses	Frequency	Percent (%)
<b>Meals frequency per day</b>		
1-2 Meals	8	13.3
3 Meals	35	58.3
More than 3 Meals	17	28.3
<b>Total</b>	<b>60</b>	<b>100.0</b>

**Source:** *Field Data, (2025)*

The findings indicate that while many households are aware of the need to provide at least three meals daily, a substantial number still provide fewer meals (1–2 per day), putting children at risk of undernutrition. The relatively low proportion of children receiving more than three meals suggests that meal frequency above the minimum recommended level is not common, possibly due to economic or food availability constraints. Three meals per day might seem adequate, but if dietary diversity is low (i.e., the meals consist mainly of starchy staples such as maize porridge and ugali, children may still lack essential nutrients for healthy growth and development. During interviews with caregivers, it was revealed that the majority of households provide only 1–2 meals per day, which was considered insufficient to meet the dietary needs of children under five. Most mothers indicated that limited income and availability of food were the main reasons for providing fewer meals. One discussant in Mahongole stated:

We try our best to give food to children, but many times we can only afford porridge in the morning and ugali in the evening. Giving three meals is hard for most families” (FGD with mothers, Mahongole, 15/08/2025).

Regarding child feeding responsibilities, another participant reported:

Feeding children is mainly the duty of mothers. Fathers are busy with farm work and sometimes children are fed by house girls if mothers are not at home” (FGD with caregivers, Rujewa, 15/08/2025).

The current findings of the study align with the findings of Msuya *et al.* (2022), who found that children having smaller foods every day are at a greater risk of being stunted and underweight. Similarly, Mwanga & Mvungi (2021) concluded that inadequate caregiver workload and attention to the timing of meals adversely affect the child nutrition in Tanzanian families. Therefore, the frequency of meals and consumption of feeding functions should be improved and the role of feeding should be fairly distributed. The study showed that households provide only 1–2 meals per day, with child feeding responsibilities primarily falling on mothers and house girls. The result of the study show that limited income and food availability constrain meal frequency, while mothers often manage feeding alone due to fathers’ absence. The findings of the study demonstrates that inadequate meal frequency and concentrated feeding responsibilities contribute to insufficient caloric intake and poor nutrient provision, heightening the risk of malnutrition among children.

### 4.3 Distribution of feeding responsibility by respondents

The respondents were asked to state the feeding responsibility in the study area. Whereas, Table 13 presented that, only 5% of respondents stated that fathers were involved in feeding children, while a majority, 95% of respondents reported that fathers were not involved. This shows that child feeding is predominantly regarded as a female responsibility, either by mothers, grandmothers, or house girls. Such gendered roles limit shared responsibility in child care and contribute to nutritional challenges, especially when mothers face economic or social pressures that hinder their ability to provide proper nutrition. The result of the study shows that the feeding responsibility was left mostly to female respondents and fathers to stay idle and providing food. The feeding responsibility to be only to women's mostly pose a workload to women's, therefore, they fail to feed the children in time. The study shows that there was a sign of masculinity nature in feeding responsibility in the study area and males see feeding as a major role to females and not to males. The study further shows that the male's responsibility is the provider but although they not involve in feeding practice but also fail to provide enough nutritious food. The findings of the study highlight the fact that child feeding has been seen as a longtime held misconception as a female sphere, which is most often carrying out by mothers, grandmothers, or the domestic workers (house girl). Extensively spread out over households, the continuation of gender domestic roles seemingly limits the sharing of caregiving responsibilities and clearly leads to health problems among children, with no opportunities to offer adequate nutrition potentially due to economic or social constraints on wage income of career mothers.

**Table 13 Children feeding responsibility by the respondents (n=60)**

Responses	Frequency	Percent (%)
<b>Child Feeding Responsibility</b>		
Mother	24	40
Father	3	5
Grandmother	5	8.3
House girl	28	46.7

**Source:** *Field Data, (2025)*

The result of the study shows that, although feeding responsibility was solely left to females but females also left to house girl. The study shows that the feeding responsibility is mostly undertaken by house girl whereas, most of the household range from 12 to 17 years old. According to the united republic of Tanzania constitution defines that any person under eighteen years is termed as children, therefore this house girl is also a child, they do not even know how to feed children, how many to feed children and the amount need to feed the children but most parents they left the responsibility to the house girl who fail to feed children nutritious food. During interviews with caregivers and community leaders, it was noted that fathers' participation in child feeding is very limited. Out of 60 respondents, only a few reported that fathers ever get involved in preparing or feeding children. One key informant from Ruiwa and Ubaruku explained:

In this village, feeding children is a woman's job. Fathers provide money or food if they have, but they don't sit to feed the child. If a mother is away, sometimes the grandmother or a house girl will do it" (Interview with Community development Officer, Ruiwa, 12/08/2025).

The study in FGDs further noted that:

Men believe that their work is to find food but not to cook or feed children. If a man is seen feeding a baby, others laugh at him and say he is controlled by a woman" (FGD with caregivers, Ubaruku, 15/08/2025).

The findings of the study were supported with empirical data as conducted in Mgina *et al.* (2020) have listed those weaknesses in paternal involvement increase the vulnerability of children to malnutrition. Similarly, Msuya and Shayo (2021) have stated that normative limitations to fathers' participation reduce the household nutritional capacity, which is even more noticeable in low resource settings. The findings of the study indicated that only 5% of fathers participate in child feeding, leaving the majority of responsibility to mothers, grandmothers, or house girls. Qualitative insights revealed that cultural norms and societal expectations discourage fathers from involvement, reinforcing gendered roles in childcare. Therefore, the findings of the study highlights that limited paternal participation exacerbates maternal workload, reduces the household's capacity to ensure adequate nutrition and increases the vulnerability of children to malnutrition. Promoting male involvement in child feeding is therefore essential to improve child nutrition outcomes.

#### 4.4 Respondent's perception in malnutrition in the study area

Study findings in Table 14 shows that 18.3% viewed malnutrition as normal, 41.7% considered it a sign of poverty, 30% perceived it as a health problem and 10% reported that it was not discussed. Furthermore, 66.7% of respondents reported that stigma is attached to malnourished children, while 33.3% said no stigma exists. Finally, 71.7% confirmed that malnutrition among children under five is observed in their community, compared to 28.3% who disagreed. The findings of the study imply that despite a certain degree of the awareness about malnutrition, there are still major stigma and stereotypes which scare away the impacted families when trying to receive the healthcare or nutritional assistance in time. The findings coincide with those of Mwanga and Mvungi (2021), who have recorded how the lack of stigma and a poor understanding of malnutrition in communities in Tanzania can postpone care seeking and deteriorate the negative health among children. In the same way, Msuya *et al.* (2022) found that perception on a community level significantly affects the levels to which the families adopt the recommended feeding behavior and uptake the offered nutrition services.

**Table 14 Respondent's perception in malnutrition in the study area (n=60)**

Responses	Frequency	Percent (%)
<b>How community view underweight or malnourished children</b>		

Normal	11	18.3
Sign of poverty	25	41.7
Health problem	18	30
Not discussed	6	10
<b>Stigma attached to malnourished children</b>		
Yes	40	66.7
No	20	33.3
<b>Presence of Malnutrition to children under five years</b>		
Yes	43	71.7
No	17	28.3

**Source:** *Field Data*, (2025)

The result of the study shows that there is presence of malnutrition in the study area, the community perception regarding the malnutrition remains as constant that malnutrition is anormal problem. The study show that most respondents show the malnutrition as not a serious issue to children health and most of them are not taking any measures. During interviews with community members, it was found that perceptions of malnutrition varied widely. Some respondents viewed malnutrition as a normal condition, others as a sign of poverty, while others recognized it as a health problem that needs attention. One community health worker reported that many families do not take malnutrition seriously. They think a child being thin is normal and do not seek help until the child is very weak” (Interview with CHO, Ipwani, 12/08/2025). On the other hand, the participants in FGDs were also reported that:

People fear being laughed at when they go to the health facility with a malnourished child. They feel ashamed because neighbors will say they do not care for their children (FGD with mothers, Ruiwa, 15/08/2025).

The findings of the study found that perceptions of malnutrition vary: 41.7% of respondents associate it with poverty, 30% recognize it as a health problem, while 18.3% consider it normal. Additionally, 66.7% reported stigma attached to malnourished children. Qualitative evidence confirmed that fear of stigma and misconceptions about malnutrition prevent timely care-seeking and adherence to proper feeding practices. Combined, these findings indicate that community perceptions and social stigma significantly influence child nutrition by limiting the utilization of available healthcare and nutritional interventions.

## 5. Conclusion

The study assessed the determinants of malnutrition among children under five years in Mbarali District and concluded that economic, social and cultural factors strongly contribute to the persistence of child malnutrition. Low household income, unstable employment and high food prices significantly reduce families’ access to nutritious foods, leading to poor dietary diversity and inadequate child growth. Social factors, including limited maternal education, poor healthcare access and weak family support systems, were also found to hinder effective child feeding practices. Furthermore, cultural beliefs, gender roles and food

taboos greatly influence dietary habits particularly restrictions on protein-rich foods such as eggs, meat and milk which negatively impact children's nutrition. Therefore, malnutrition in Mbarali District is a multifaceted issue rooted in economic hardship, social inequities and cultural traditions, requiring integrated and context-specific interventions for meaningful improvement.

## 6. Recommendations for Action

To address malnutrition among children under five in Mbarali District, the study recommends a multi-faceted approach targeting economic, social and cultural determinants. Strengthening household income-generating activities such as small-scale businesses, poultry and livestock keeping and agricultural value addition can increase families' food purchasing power and improve dietary diversity. Implementing food price controls and expanding social protection programs, including cash transfers, food vouchers and school feeding initiatives, will ensure that low-income households have consistent access to nutritious foods. Additionally, maternal nutrition education programs should be enhanced at both community and health facility levels to promote exclusive breastfeeding, timely complementary feeding and balanced meal planning, while improving healthcare service quality through reduced waiting times, availability of nutrition supplements and caregiver-friendly services. Furthermore, culturally sensitive community interventions are essential to address harmful food taboos, encourage equitable gender roles in childcare and foster community-wide awareness about proper nutrition. Engaging local leaders, religious institutions and community health workers as advocates for these practices will strengthen the adoption of positive behaviors. Collectively, these strategies aim to create a supportive environment that empowers caregivers, improves child feeding practices and reduces the prevalence of malnutrition in the district.

### 6.1 Recommendations for Further Study

This study focused specifically on Mbarali District to examine the economic, social and cultural determinants of malnutrition among children under five years old. Future research should be conducted in other districts and regions of Tanzania to allow for comparative analysis and the identification of regional variations in the causes and patterns of malnutrition. Longitudinal studies are also recommended to explore the long-term impact of income-generation initiatives, nutrition education programs and cultural interventions on improving child nutritional status. Additionally, future studies could examine the role of climate change, agricultural practices and community-based nutrition programs in shaping food security and child health outcomes at the household level.

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