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The Misbeliefs and Food Taboos During Pregnancy and Early Infancy: A Pitfall to Attaining Adequate Maternal and Child Nutrition Outcomes

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Abstract

Maternal and child nutrition is fundamental to ensuring healthy pregnancy outcomes, optimal fetal development, and child growth. However, cultural misbeliefs and food taboos during pregnancy and early infancy continue to pose significant barriers to achieving adequate nutritional outcomes in many societies. These practices are often rooted in traditional beliefs, social norms, and misconceptions regarding the effects of certain foods on maternal health, fetal development, childbirth, and infant well-being. As a result, pregnant women may avoid nutrient-rich foods such as eggs, fish, meat, fruits, and vegetables, while infants may be subjected to delayed breastfeeding, early introduction of inappropriate complementary foods, or restrictions on essential dietary components. Such dietary limitations can contribute to maternal undernutrition, micronutrient deficiencies, low birth weight, stunting, impaired cognitive development, and increased susceptibility to illness among children. This paper examines the prevalence and underlying determinants of food taboos and nutritional misbeliefs during pregnancy and early infancy, and their implications for maternal and child health outcomes. Furthermore, it highlights the importance of culturally sensitive nutrition education, community engagement, and evidence-based interventions to address harmful dietary practices while respecting local traditions. Promoting accurate nutritional knowledge among mothers, families, and communities is essential for improving maternal and child nutrition and advancing global health and sustainable development goals.

Keywords: Food taboos, maternal nutrition, child nutrition, pregnancy, infant feeding practices, cultural beliefs, nutritional misconceptions, maternal and child health, dietary practices, undernutrition.

INTRODUCTION

In developing countries, the practice of food taboo is widespread. The types of foods considered as taboos, and the reasons attached to the taboos vary from society to society. The deliberate avoidance of a specific food item for

reasons other than a simple dislike of food preferences especially during pregnancy bears dire consequences for the mother and her unborn child due to important nutrient depletion. Though adequate dietary intake during pregnancy could be affected by many factors, food taboo has been recognized as one of the factors contributing to maternal under-nutrition in pregnancy, especially in rural settings. Despite this recognition, little is known about the ontribution of these misbeliefs and food taboos to maternal and child nutrition outcomes in Uganda and in particular Acholi sub-region where malnutrition is prevalent. This study, therefore, aims to explore various misbeliefs and food taboos in the time of pregnancy that can influence maternal and child nutrition outcomes in Acholi.

Food taboos exist in one form or another in every society on Earth. Nowhere in the world do people, a tribe, or an ethnic group exploit the full potential of edible resources in their surroundings (Simoons 1994). For example, the hunters and gatherers of the Paraguayan jungle (the Ache people) are believed to exploit only 50 of the several hundreds of edible mammalians, avian, reptilian, amphibian, and piscine species found in the tropical forest. As with plants, fruits, and insects, only 40 of them are exploited. Ninety-eight percent of the calories in the diet of the Ache are supplied by only seventeen different food sources in the tropical forest (Hill and Hurtado 1989). The term Food taboo is used to describe the deliberate avoidance of a specific food item for reasons other than a simple dislike of food preferences (Meyer-Rochow 2009). However, in almost all societies food taboos are understood as a systematic set of rules about which foods or combinations of foods may not be consumed (Arzoaquoi, Essuman et al. 2015).

Although ordinary restraint from certain foods may in itself not mean food taboo, regular avoidance usually culminates into a tradition and eventually as a food taboo (Harris 1985, Harris and Ross 1987, Hill and Hurtado 1989). Social anthropological research on eating and food taboos underpins habitual avoidance of foods as stemming from utilitarian doctrine, and magico-religious motives (Harris 1985, Mintz and Bois 2002). The delineation of food taboos as mechanisms for conserving resources as well as a person's health has been documented by functionalists (Blommaert 2005). The explanation of rituals and taboos based on spiritual, religious, and magic ideation has also been cited (Hossen et al., 2026)

In developing countries, the practice of food taboo is widespread. The type of food considered as taboo, and the reasons attached to the taboos vary from society to society. In most settings, food taboos often target pregnant women to prevent what is perceived as harmful effects of these foods on the newborn (Martínez Pérez and Pascual García 2013, Ekwochi, Osuorah et al. 2016). For example, a study in South Africa revealed that foods such as meat, fish, potatoes, fruits, beans, eggs, butternut, and pumpkin, which are good sources of in essential nutrients are avoided (Chakona and Shackleton 2019). In Ethiopia, food items such as linseed, honey, sugarcane, milk, yoghurt, cheese, fatty meat, eggs, fruits, and vegetables are excluded from the diet (Zepro 2015). In Gambia, Nigeria, Gabon, the Democratic Republic of Congo, and Asia, pregnant women are usually forbidden from consuming the richest food sources of iron, carbohydrates, animal proteins, and micronutrients (Alam et al., 2025)

For many cultures in Uganda, there is a belief that being loyal to food-based taboos often results in a healthy pregnancy. For instance, in Buganda, taboos restrict pregnant women from eating slaughtered animals. In Karamoja, women are debarred from eating the meat of dead animals, offal, and chicken. Lack of adherence to these taboos is believed to result in pre-eclampsia, general body weakness, being sickly, abnormal fetus movement, miscarriages, abdominal pains, malaria and fevers, weight loss, being pregnant beyond the gestation period of nine months, bleeding, vaginal discharge, and sexually transmitted diseases (Atekyereza and Mubiru 2014, UNICEF 2015). Other studies elsewhere in the world other than in Uganda, also show similar reasons for avoidance of other food items. The avoidance of certain foods was linked to adverse pregnancy outcomes (macrosomia, dystocia, fear

of miscarriages or abortion, and fetal abnormalities), labor, and avoiding an undesirable body appearance for the baby (Zerfu, Umeta et al. 2016, Chakona and Shackleton 2019).

Malnutrition especially among pregnant women and adolescents increases the risk of maternal and neonatal mortality and morbidity, low birth weight babies, slow growth, and impaired cognitive development, which often translate to an intergenerational cycle of malnutrition. Addressing existing barriers is critical to ensuring adequate maternal nutrition during pregnancy and lactation. Even though adequate dietary intake during pregnancy could be affected by many factors including food affordability and accessibility, food taboo has been recognized as one of the factors contributing to maternal under-nutrition in pregnancy; especially in rural settings (Oni and Tukur 2012, Gadegbeku, Wayo et al. 2013). Despite this recognition, little is known about the contribution of these misbeliefs and food taboos to maternal and child nutrition outcomes in Uganda and in particular Acholi sub-region due to limited literature (Mohd Pauzi & Shahadat Hossen, 2025).

The rationale of the study

This study envisaged to inform policies and programmes on the choice of approaches that could lead to tailored interventions to tackle maternal and child undernutrition in the rural areas of Uganda. This is expected to improve the nutritional practices and health of women, infants, young children, and adolescents for optimal child survival and development outcomes, with the view of breaking the intergenerational cycle of malnutrition (Alam et al., 2025).

RESEARCH METHODS

This study was conducted in the Acholi sub-region located in Northern Uganda. Acholi Sub-region is composed of eight districts, namely, Gulu, Kitgum, Lamwo, Pader, Agago, Amuru, Nwoya, and Omoro. Five districts, Gulu, Omoro, Amuru, Pader, and Kitgum were sampled for this study. The Acholi are one of approximately 65 ethnic groups in Uganda with a population of over 1.5 million (UBOS 2014). The Acholi area stretches across a vast majority of northern Uganda with the border of Sudan and covers nearly 11,264 square miles (Atkinson 1989). This accounts for 12% of the total land area of Uganda. The Acholi live within a vast diversity of forests, plains, dry lands, and rivers. The fertile land supports hunting, fishing, animal rearing, and the growing of various crops. Major food crops of the Acholi are plantains, cassava, millet, sorghum, maize, sweet potatoes, beans, and groundnuts; while the major cash crops of the area are coffee, tea, and tobacco (Kasozi, Musisi et al. 1994, Odoki 1997). Livestock such as goats, sheep, cattle, and poultry are reared for domestic use. There are 132 government health facilities in Acholi sub-region. These comprised of 116 HC III, 9 IV and 7 hospitals. Depending on the level, these facilities provide out-patient and in-patient services, emergency, and obstetric care services (Mangwi Ayiasi, Rutebemberwa et al. 2019).

Research design and participants

This study was conducted between April and May 2022. A community-based qualitative cross-sectional study design using focus group discussions (FGDs) and in-depth interviews (IDIs) of Key informants (KIs) was used. The methods were chosen to allow for in-depth probes due to sensitivity around the practices. Participants were selected from five districts, three from west Acholi i.e., Gulu, Omoro, and Amuru, and two others from east Acholi i.e., Pader and Kitgum. Study participants included the Health Care Providers (HCPs) attached to the antenatal clinic (ANCs), Village Health Team (VHTs), Traditional Birth Attendants (TBAs), Rwodi of Ker Kal Kwaro Acholi, pregnant women, and their spouses (Hossen et al., 2023).

Participants recruitment.

Purposive sampling techniques were used to select the KI and FGD participants. Pregnant women attending

antenatal clinics in five rural government health facilities in the sampled districts namely, Gulu, Amuru, Omoro, Pader, and Kitgum were purposively selected to participate in the study. Atiak HC IV in Amuru, Awach HC IV in Gulu, Lalogi HC IV in Omoro, Pajule HC IV in Pader, and Namukora HC IV in Kitgum district were the health facilities sampled for the study. These facilities were chosen because of their rural location and the capacity to offer obstetric care services. Records of women were obtained from registers available at the health centres. Only those who meet the selection criteria (i.e., be pregnant, able to speak the local language, live in a rural area, are not weak/sick, have a partner living together, and are willing to give consent) were selected. Partners of women attending ANCs automatically became potential KII participants. Phone numbers of spouses of women attending ANC were obtained from the medical records for telephone interviews. The Rwodi of Ker Kal Kwaro Acholi were identified and selected from the 54 chiefs listed in Ker Kal Kwaro Acholi's Strategic Plan 2009 document. Telephone contacts of the Rwodi were obtained at the time of selection to schedule interview appointments. Village Health Team (VHTs) were identified from the staff inventory available at the targeted health facilities. Lists of the former TBAs registered with the respective health authorities were obtained and participants were identified to participate in the study (Rashed et al., 2025).

Data collection tools and methods

Fourty semi-structured interviews using a pretested interview guide were conducted with the key informants to gather a range of views regarding misbeliefs and food taboos during pregnancy and early infancy. The interview guides were updated whenever an information gap was discovered. In-depth Interviews were conducted with the KIs participants i.e., 10 Rwodi (chiefs of Ker Kwaro Acholi) from across the 5 selected Acholi districts to harness a range of views and opinions, 10 health care providers attached to the Ante-Natal Clinic, and 05 Village Health Team (VHTs), 05 spouses (husbands) of the pregnant women, and 10 former Traditional Birth Attendants (TBAs). Nine out of ten FGDs were conducted with 8-10 purposively selected pregnant women. Interviews with the health care providers and pregnant women were conducted from the health facilities. All the other participants (Rwodi, VHTs, TBAs, and partners of pregnant women) were interviewed from their respective homes either via telephone or face to face. All interviews were conducted in the medium Acholi language by the Principal Investigator (PI) and trained Research Assistants. The decision on the actual number of in-depth interviews to conduct with the KIs and FGDs with pregnant were reached based on the level of information saturation which was ascertained by transcribing the discussions of each day's session. All data were audio-recorded. Notes and memos of participants' behavior and contextual aspects were taken during the interviews. The FGDs took on average between 40 - 60 minutes while IDIs with the KI took an estimated 30 - 40 minutes. Some KI participants especially Rwodi and TBAs whom the research team could not meet in person were interviewed on phone. Also, the interviewing of spouses of pregnant mothers was done via telephone calls (Rahman et al., 2025).

Data analyses

The audio recordings and field notes taken during the FGDs and KIIs were transcribed verbatim and analyzed manually using systemic text condensation principles (Gale, Heath et al. 2013). Transcripts were reviewed several times to fully understand the texts' overall content, pick out the actual meaning in the transcript, condense the content using color coding, and create categories that contain the condensed meaning of the main themes in the transcript. The data were then organized into themes. Parts of the discussions were quoted verbatim, and some were modified to improve clarity. Results were presented as narratives using the verbatim of the respondents to elucidate and further provide proof for key statements. All quotes were translated from the local language (Acholi) to English. Basically, the phases of the thematic analysis of the qualitative data were: - data transcription, data familiarization, initial code generation, thematic search and reviews, thematic definition and naming, and finally reporting (Hossen & Pauzi, 2025).

RESULTS

Socio-demographic characteristics of the study participants

Nine out of ten FGDs with a total of 86 participants were held. Key Informant Interviews were conducted with 32 participants. Overall, a total of 118 respondents participated in the eight FGDs and Twelve KIIs. The final number of in-depth interviews and FGDs conducted was established based on the level of information saturation which was ascertained after transcribing the discussions of each day's session by the research team.

The study participants consisted of 86 pregnant women, 8 Rwodi of Ker Kal Kwaro Acholi, 7 Health Care Providers, 9 former Traditional Birth Attendants, 4 Village Health Teams, and 4 spouses of pregnant women. The participant's age groups ranged from 16 – 82 years old. Their educational status varied widely i.e., ranged from no education to tertiary formal education. Ninety-five percent of participants lived in rural areas and 83.1% engaged in agriculture as their major occupation except for health care providers and some Rwodi (Table 1).

Table 1. Socio-demographic characteristics of respondents

Respondent's characteristics	Category	Number	Percentage
Age range	15-18	22	18.6
	19-35	55	46.6
	36-45	24	20.3
	46 and above	17	14.4
Sex	Male	17	14.4
	Female	101	85.6
Residence	Rural	112	94.9
	Urban	6	5.1
Occupation	Agriculture	98	83.1
	Formal employment	6	5.1
	Unemployed	14	11.9
Education	No education	35	29.7
	Primary	69	58.5
	Secondary	8	6.8
	Tartiary	6	5.1

Main factors that determine food choices in the community

Participants were asked about their opinions regarding factors that determined food choices during pregnancy in their communities. Varied views were expressed to explain why some people chose what to eat and what not to. Most of the respondents particularly pregnant women, TBAs, and Health Care Providers believed that most women have specific food preferences because of the existing medical conditions, cultural beliefs, level of income, availability of the food items, prescribed menu, individual preference, state of pregnancy, as well as knowledge about food and nutrition. A KII participant, Traditional Birth Attendant stated,

"……. for me I have ulcers and my doctor advised me not to consume sour food such as oranges, Malakwang, soda, and or eat beans……."

Another TBA elaborated on how a household or individual economic status can influence which food to eat and

what food to forgo.

"……. If you do not have money, there is no way you can eat the foods you like. Now with the current economic crisis and food insecurity, foods have become very expensive and scarce. You just have to eat whatever is available……."

One KII participant added,
"….. the Acholi culture dictates what pregnant women should eat and what they shouldn't. For example, women are banned from eating bush meat when they are pregnant. This kind of belief does not only restrict women from eating such food but also affects the entire household's food choices……"

A FGD participant pregnant woman indicated,
"…… Pregnancy period can be a very confusing moment in a woman's life, especially in the first and second trimesters. I almost detested all foods in my first three months of pregnancy with my second born. Most often, a simple smell of certain food would make me vomit everything from my stomach…."

Another KII participant, a health care provider associated food preference with the education of the woman. She explained that knowledge about nutrition contributes a lot in determining what one should eat.
"……. If you know the food groups that are good for your health for example when you are sick or pregnant, you will rightly choose the types of food to include on the menu……"

Similarly, another FGD participant pregnant woman reckoned,
"……. Food availability is a major reason for differing food choices. You might have cash but if the food you want to buy is not available in the local market, what can you do? You will have to change your plan and look for alternatives. For me, if I want to eat fish and I don't find it in the market, I go for silverfish….."

Foods that are considered special to pregnant women and newborn babies
Pregnant women and their spouses, healthcare providers, TBAs, and VHTs believed that some foods are 'special' for expectant mothers and their newborns. For the pregnant mothers, foods such as meat; leafy vegetables (pumpkin leaves, *boo*, cabbage, *Malakwang*, *Akeyo*); Silverfish; millet food; Soybean porridge; carrots; milk; Fruits (pawpaw; Avocado), and Pumpkin leaves were reported as special and should be consumed as much as possible. These foods are perceived to fatten and offer general nourishment to the baby while in the womb. *Malakwang* is consumed specifically to enhance the milk let-down during breastfeeding.
For newborns, breast milk is given exclusively in the first two months. Some mothers however introduce sugar solution, black tea, and soup immediately after birth. From 3 months onwards the infants are given soybean, millet, and maize flour porridge mixed with sesame or groundnut paste.
A pregnant mother, a participant of a FGD indicated,

"……. when my third born was in the womb, I ate a lot of pumpkin leaves, and the baby came out very big that I almost failed to deliver normally……."

A KII participant, one of the Traditional Birth Attendants also expressed her experience with her first-born son. She stated,
"…….. Pasted foods are miracle meals during pregnancy. In my first pregnancy, my mother-in-law advised me to include pasted beans, Malakwang, Boo, Akeyo, porridge, and meat in my diet. I did that and the outcome was

amazing when I gave birth. My son came out all glittering and very big……"

Additionally, another KII participant, a Health Care Provider, stressed that maternal nutrition during pregnancy should be given careful attention. Meal planning should include the different food groups available within the community. These foods should be able to provide essential nutrients for nourishing both the mother and the growing fetus. Thus, foods rich in carbohydrates, proteins, minerals, and vitamins should be included in daily diet. Micronutrient supplementation especially of iron and folic acid is equally important. These can be started right before the woman conceives and continued during pregnancy until 3 months postpartum. For infants younger than 6 months, exclusive breastfeeding is advised. The participant added,

Foods that are considered taboos in Acholi community and the reasons linked to them

FGD and KII participants indicated that certain foods are taboos in some Acholi clans and should not be eaten or even touched by pregnant women. Overall, 14 foods are held as taboos across the Acholi community with various reasons attached to them (Table 2). FGD and KII participants mentioned avoidance of high carbohydrate foods especially sugarcane and honey during pregnancy. Consumption of these foods was viewed to be associated with generalized fetal skin fissures and having a newborn with excessive birth weight which was believed to lead to a difficult birth. A KII participant, a TBA uttered,

"……. My son almost killed me if I was not an experienced TBA. He was too big because I ate too much honey in the three last months of my pregnancy. I got a lot of tears during delivery….."

Table 2. Summary of foods considered as taboos during pregnancy and reasons attached to them, Acholi subregion, Northern Uganda, 2022

Taboo foods	Reasons for the ban	Participants who mentioned the taboo foods and reasons
Offals	It causes the umbilical cord to tie around the neck of the fetus	Majority of Pregnant women and Health Care Providers
Chicken and chicken's skin	It causes miscarriage and the skin chokes the fetus	Majority of the TBAs, Pregnant mothers and their spouses
Wild birds	Causes blindness to the fetus	Few pregnant women
Smoked meat and fish	Causes navel/umbilical cord infection	Majority of the pregnant mothers
Sugarcane	Causes generalized fetal skin fissure	Majority of the pregnant mothers, TBAs, and VHTs
Garden egg ('Tula')	Skin inflamation to the fetus	Most of the TBAs
Groundnut	It causes whitish plasters onto the fetal baby	Majority of Pregnant women
Bush meat	Causes miscarriage	Most of the Rwodi and TBAs
Mushrooms	It causes miscarriage; infertility in women; and body sores to the fetus	Most of the Rwodi and TBAs
Honey	It causes macrosomia	Few of the TBAs

Sour fruits or meals	Causes fetal skin rashes	Few of the TBAs
Goats meat	To show respect for the men	Few of the TBAs, Rwodi and Spouses of pregnant women
'Lalaa' (the bitter green leafy vegetable)	Causes erectile dysfunction (impotence) to the newborn child	Majority of the TBAs, Pregnant mothers and their spouses
'Lamola' (Hyptis spicigera) also known as the black sesame	Causes fetal blindness	Majority of the TBAs and Pregnant mothers

Similarly, a FGD participant, a pregnant mother added,
"….. My own brother's son was born with generalized skin cracks and tears when the monther consumed sugarcane during her pregnancy. It took some time for the wounds to get completely healed. In fact, the boy bled too much at the time of his birth that we thought he would die……"

The consumption of protein-rich and nutrients dense foods such as offal, smoked meat, fish, chicken, goat's meat, and wild meat is restricted during pregnancy because of various reasons depending on the clan. Many of the participants believed that eating offal and chicken skin, particularly during advanced pregnancy causes 'baby strangling', a condition in which the the umbilical cord ties around the baby's neck leading to choking. Handling or eating smoked meat and fish a few weeks prior to childbirth is feared to cause infection of the umbilical cord after the baby is born. The perception behind barring women from eating goat's meat and chicken is basically to show respect for the men. One of the KII participants, Rwot, emphasized,

"……. In Acholi, women are banned from eating goat and chicken because these foods are very small whenever cooked and so served only to the men. Usually, more than one meal is prepared on the day chicken or goat would be cooked. The women eat the other foods while the meat is left for the men. This is a sign of respect that has been in practice from time immemorial……"

Cultural dictates

It's apparently clear that every clan in Acholi has its own cultural beliefs that they hold so dearly, and it's expected that every member of the clan adheres to them. Failure to comply with the taboos tantamount to being thrown out as an outcast or facing grave consequences. When a man marries a woman, she is first allowed to stay with her mother in laws for about a year before moving to her own house to start living independently. During this time, she is taken through the dos and don'ts of that family that she must follow. This kind of informal teaching goes on for generations after generations. The message is passed to children usually from an informal setting called 'wang oo' (literally meaning the fireplace). One KII participant, a Traditional Birth Attendant, testified,

"……. when I eloped, I first stayed with my mother-in-law for eight months. While I was with her, she groomed me into becoming a woman of the home. She told me never to eat meat before I was oriented. She also advised me never to eat mushrooms if I think I'm pregnant to avoid miscarriage……"
To further support the claim, another FGD participant, a pregnant woman added,

"……. Back in those days, my father used to tell us from 'wang oo' never to eat chicken when I'm married. He added it was disrespectful for a woman to eat chicken. This got stacked in mind and up to now I still do not eat chicken….."

Individual characteristics

Some taboos are linked to spiritual attachment and or appeasement. It was vividly expressed by many of the participants that some clans in Acholi have '*jok*' (the spirit) that they respect. The '*jok*' can befall any member of the clan. Usually, the spirit demands avoidance of certain foods, and failure to adhere to the wish of the spirit, the individual could face severe consequences. One KII participant, a TBA, expounded,

"……. The 'jok koma' (my spirit) does not allow me to eat any four-legged animals. When I eat it, I get paralyzed and develop sores all over my body. This started when I was still young and, in my life, I haven't eaten any meat from animals with four legs. There was a day I accidentally ate beef from a wedding ceremony, I almost died, I completely became paralyzed, and people could not explain what was happening to me…."

Social dimensions

From the views expressed certain taboos seem to be losing relevance but societal pressure and influence appear to play a big role in holding people onto it. Society often expects adherence to preset norms without questioning. There were general concerns that elders, particularly older women usually impose and or dictate certain taboos on younger women. Adherence to some taboos was thus linked to fear of reprimand and rejection. One of the FGD participants, a pregnant woman, expressed,

"……. My mother-in-law told me his son would not take cows to our home if I indulged in eating meat. I asked myself how eating meat was related to my marriage……."

Another KII participant, a TBA, added,

"……..When I was a girl, my mother told me never to eat chicken if I want to be a respectful girl. She gave me an example of a girl in the neighborhood who was chased from her marital home foeating the gizzard of a chicken….."

Misbeliefs and other taboos during pregnancy in Acholi community.

Respondents were further asked about their awareness regarding other taboos or misconceptions attached to pregnancy. Most of the KII and FGD participants expressed varied views pertaining to taboos that pregnant women should respect. A total of 9 issues were raised during interviews with key informants and discussions with the focus group participants (Table 3).

Table 3. Summary of other taboos/misbeliefs during pregnancy and reasons attached to them, Acholi sub-region, Northern Uganda, 2022

Misbeliefs/other taboos	Reasons attached to it	Participants who mentioned the misbelief/taboo and reasons
Anybody who killed a bird should not enter a house where a pregnant woman is lives	Causes fetal blindness	A few of the pregnant women
Pregnant women should not touch soil from graves	Causes miscarriage	A few of the pregnant women
Pregnant women are not allowed to shape or shave their hair (it makes the baby's head bald)	It makes the baby's head becomes bald	A few of the pregnant women

Pregnant women should not walk over anthills	It causes miscarriage, body and sore tongue	Majority of the TBAS, Spouses of the pregnant women and a few of the pregnant women
Pregnant women should not slaughter chicken or touch slaughtered chicken	It causes miscariage	Majority of the TBAs and pregnant women
Pregnant women should not have sex especially in the 3rd trimester	Causes the sperm to plaster onto the fetal body	Majority of the Pregnant women and their spouses
Pregnant women are not allowed to sit on animal's hide or skin	Causes miscarriage	A few of the TBAs and Rwodi
Pregnant women are not allowed to touch needle	Causes miscarriage	Majority of the TBAs, Pregnant women and Rwodi

Five out of nine taboos mentioned were linked to miscarriage. KII and FGD Participants expressed that most of the Acholi taboos especially those practiced during pregnancy aim at protecting the fetus. In support of these views, one of the Rwodi of Ker Kal Kwaro Acholi stated,

"…….. in our culture, taboos during pregnancy are meant to protect the fetus from coming out preterm. People tend to adhere more to taboos than formal laws because of the immediate consequences associated with it. So we use taboos to shape behaviors that would harm lives and societies….."

Although in some clans these beliefs and taboos are still strongly held, majority of the respondents think that the adherence to such things is waning in most Acholi communities. A FGD participant, a pregnant mother, and a KI respondent put it straight that,

"……. These things called taboos no longer work. Women have held needles, sat on hides or skins, and ran over anthills but nothing happened to them. We need to find a way of detaching ourselves from such attachments……."
However, one of the spouses of a pregnant woman indicated that,
"……It's unfortunate that today's generation is losing track of their culture. Taboo in some clans is alive, let no one deceive you that these things are outdated. A case in point, in the neighboring clan last year, a pregnant woman in the fourth month of pregnancy had a miscarriage because she walked over an anthill when she went to fetch firewood. It really depends on the family one come from……"

DISCUSSION

This study explored the misbeliefs and food taboos during pregnancy and early infancy among the rural Acholi communities in Northern Uganda. From the results, participants of age 36 years and above were richer in information regarding food taboos than their younger counterparts. The younger people especially those younger than 18 years felt a bit uncomfortable talking about the topic even when the researcher could see the responses in their faces. The researcher was able to probe and make the discussions more interactive and participatory to enable them to bring out the issues clearly. In Acholi, it's forbidden to talk about taboos in public, especially by young people and this could explain why younger respondents felt uneasy discussing it. Their role is simply to adhere to it. The information gap about food taboos among young people could also be due to the breakdown in the informal teaching system, the '*Wang oo'*. One of the Rwodi of Ker Kal Kwaro Acholi indicated that most young people are

losing directions and are becoming ignorant of their culture because the '*Wang oo'* which used to be a sort of informal school is no longer common. Fournier (2019) reported that the 20 years civil war in Acholi, injured the formal space to bind the community. The cessation of the *Wang oo*, (a central, communal fireplace where elements of the culture – stories, songs, riddles, and parables were told and passed) severely undermined the cultural systems and the continuity of traditional values from one generation to the next (Harlacher, Okot et al. 2006, Finnström 2008). Also, the advent of Christianity and formal education as explained by one of the respondents, distanced children even more from older people who could be a rich source of information.

Among the Acholi community, food taboos seem to target women more and men to a lesser extent. Most of the taboos mentioned other than those practiced during pregnancy excluded men. It was eminent during the discussion that women had more information about food taboos than men and the practices appeared to be more prevalent among the women. In several instances, the researcher witnessed men consulting their wives for certain responses. Lambek (1992) in his study found out that women bear heavier burdens of taboos and observance than men. He added that the gender bias of taboos raises a complex of issues related to the paradoxical relations between autonomy and values that were beyond the scope of his study. This finding agrees with the result of this study.
Results from the present study show medical conditions, cultural beliefs, level of income, availability of the food items, prescribed menu, individual food preference, state of pregnancy, as well as knowledge about food and nutrition as key factors that influence maternal nutrition during pregnancy. During pregnancy, physiological changes that occur due to hormonal interactions, excessive weight gain, fat disposition, and modification in cardiovascular, respiratory, and gastrointestinal functions can affect the woman's dietary intake (Widen and Gallagher 2014, Kazma, van den Anker et al. 2020). The changes in diet during pregnancy appear to reflect a woman's efforts to balance physiological changes accompanying pregnancy with the desire for a healthy baby. Forbes, Graham et al. (2018) found that women frequently select and accept certain foods for the health of their babies and to satisfy cravings. (Fowles and Fowles 2008, Gardner, Croker et al. 2012) reported that the interaction of individual values and beliefs about nutrition in pregnancy, nutrition knowledge, physical and physiological changes with the determinants of other eating behaviors often change the woman's food choices during pregnancy. Further compounding on results from this present study, Versele, Stok et al. (2021) found social influence, home/environment food availability, food knowledge, and self-regulation to influence food choices during pregnancy.

This study summarizes the foods considered special by the respondents into four main categories namely, carbohydrate sources (which include porridge, rice, cassava, and maize), protein sources (e.g., pulses, fish, meat, nuts legumes), fat and oil (such as nuts, '*odii*' peanut butter, and sheer butter) vitamins, and minerals (mainly from fruits and vegetables). Other components of the special nutritional requirement during pregnancy cited in this study is the oral micro-nutrient supplementation especially of iron and folic acid. For infants younger than 6 months, results show that breast milk is preferred although other respondents indicated feeding infants older than two months on sugar solution, soup, and porridge as alternative meals, especially for mothers with breastfeeding challenges. According to Trumbo, Schlicker et al. (2002) and the Academy of Nutrition and Dietetics, approximately 300 extra calories are needed each day to maintain a healthy pregnancy. These calories should come from a balanced diet of proteins, fruits, vegetables, and whole grains. Protein intake during pregnancy is 60g/day which is equivalent to 1.1g consumption of protein/kg/day (Trumbo, Schlicker et al. 2002). Meyers, Hellwig et al. (2006) recommend women to take folic acid from fortified food or supplements daily in addition to consuming a diet rich in food sources of folate to reduce the risk for neural tube defects in their offspring. Accordingly, breastfeeding and breast milk are the global standards for infant feeding. Experts advise that children should be breastfed exclusively for the first 6 months and this should continue for at least through the first year of life

(Eidelman, Schanler et al. 2012). Although the foods listed as special for women to consume during pregnancy in this study agree with other reports and recommendations, the knowledge regarding the consumption of these foods is unclear and it's beyond the scope of this present study. However, efforts to promote adherence to culturally appropriate nutrition practices and education may be an important care practice for many pregnant women.

Results from this study also revealed that food taboos during pregnancy are not practiced in isolation but in association with other established set of cultural norms. Depending on the clan, the Acholi people attach several taboos to pregnancy. In some families, a pregnant woman is not allowed to touch a bird that has been killed, touch grave soil, shape or shave their hair, walk over an anthill, slaughter chicken or touch slaughtered chicken, have sex during pregnancy, sit on animal's hide or skin, and touch needle. Reasons in support of these restrictions were mainly related to avoidance of miscarriage. The justification for avoiding sex was the perception that the sperm would plaster onto the fetal body and therefore look unpleasant during delivery. Though participants expressed the realities of consequences associated with defiance, there is no scientific evidence to explain the phenomena. Contrary to the view attached to sexual intercourse in this study, Shojaa, Jouybari et al. (2009) reported the reasons to evade sex during pregnancy among Iranian women to be associated with the fear of abortion, fetal suffocation, fetal abnormality, rupture of fetus hymen, and concern of harm to the mother. Orji, Ogunlola et al. (2002) too, found the reasons for the avoidance of sex during pregnancy among pregnant women in Ilesa, Nigeria to include nausea and vomiting during early pregnancy, fear of miscarriage, fear of harming the fetus, physical awkwardness, lack of interest, discomfort, fear of membrane rupture, fear of infection, and fatigue. It appears that the perceptions toward sexual intercourse during pregnancy as well as the nature of other beliefs and practices vary with the cultural and social contexts. A study in the District of Ilocos Sur, Philippines, Oyo State, Nigeria, and Shama District of the Western Region, Ghana reported disparate taboos and misconceptions and reasons attached to them (Ezeama and Ezeamah 2014, Otoo, Habib et al. 2015, Bermio, Reotutar et al. 2017). This is the first time an account of taboos especially during pregnancy in Acholi is documented.

CONCLUSIONS

This study unveiled the influence of food taboos, other cultural beliefs, and misbeliefs on maternal nutrition and general well-being during pregnancy within the Acholi community in Northern Uganda. Adherence to these practices was found to be driven by established cultural edicts, social contexts, and individual characteristics which vary from clan to clan. Grossly, the anxiety of losing the fetus, fear of poor birth outcomes, the suspicion that the mother would die or become impotent, and the worry of a social outcast were put forward as key reasons for the assent to these taboos. Notably, the foods condemned for consumption during gestation mainly include offals, chicken, wild birds, smoked meat, smoked fish, sugarcane, the garden egg ('*Tula*'), groundnuts, wild meat, mushrooms, honey, '*Malakwang'*, oranges, mango, passion fruits, lemon, tamarind, goat's meat, '*Lalaa*' (the bitter green leafy vegetable), and '*Lamola*', black sesame (*Hyptis spicigera*). From an expert point of view and the global standards on maternal nutrition, restricting the consumption of these vital foods during the critical period of developmental programming would likely leave dire implications on the development of the growing fetus, and maternal health incluing child growth and development later in life. From the result, health care providers appear to pay less attention to issues of taboos during their routine encounter with the pregnant women. Based on the reality expressed regarding these practices, nutritional counseling and education should focus more on addressing food taboos. Appropriate nutrition interventions targeting pregnant women and their spouses, school-going children, adolescent girls, and cultural leaders in their respective points of contact would go a long way to confronting this barrier for improved nutrition outcomes in the region. Further studies focusing on investigating the cause-effect relationship between food taboos and specific nutrition outcome is recommended.

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