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RESEARCH ARTICLE

Food Taboo and Myth among Pregnant Mothers in Gedeo Zone, South Ethiopia: A Qualitative Study

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Abstract

Introduction: Food taboos are deliberate restrictions on oneself from different types of food and drink for various reasons. Even though a balanced diet is essential during pregnancy for the health of both the mother and the fetus, pregnant women often restrict themselves from many essential nutrients, which endangers the health of both mother and baby.

Objective: The study aims to explore food taboos and myths among pregnant women in the Gedeo Zone from March 25 to May 25, 2020, in Ethiopia.

Methods: A community-based qualitative exploratory study using a phenomenological approach was conducted. In-depth and key informant interviews were employed to collect data from March to May 2020 in Gedeo. Convenient sampling was used to recruit participants from the households of targeted villages. A total of 32 in-depth interviews with pregnant women, lactating women, elderly women, and husbands were conducted. The sample size was determined based on the concept of saturation. The collected data were analyzed using thematic content analysis techniques. Data coding and analysis were facilitated using Open Code version 4.0 software.

Results: Thirty-two study participants were involved. During pregnancy, foods that are sweet, referred to as "good foods," spicy foods, and large quantities of food were considered taboo for pregnant women.

Conclusion and Recommendations: Food taboos for pregnant women were found to exist in the Gedeo Zone. Pregnant women avoid consuming large quantities of any type of food, as well as good foods, sweet foods, and spicy foods. Therefore, strategic health communication is needed to correct misconceptions such as the beliefs that pregnant women should eat less, that certain foods cause diseases in both the mother and the fetus, and that skin discoloration can occur in the fetus. Maternal and Child Health (MCH) clinics and health extension workers must play a leading role in coordinating this awareness-creation effort. They should also establish mechanisms to routinely identify women observing food taboos, assess their reasons, and provide appropriate nutrition education.

Keywords: Food taboo, Pregnancy, Perceptions, Dilla, Ethiopia

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1 Introduction

Food taboos involve deliberate abstention from consuming certain foods and beverages due to religious and cultural reasons [1, 2]. These taboos can be permanent or temporary. Permanent food taboos involve avoiding certain foods and drinks throughout one's life, while temporary taboos apply to specific periods of time [3, 4]. Pregnant women are often restricted from eating certain items, such as liver, intestines, kidneys, milk, sweet potatoes, sugar, salt, eggs, and bananas, due to fears that these foods may lead to complications, including high birth weight, difficult births, obstructed labor, and stomachaches before delivery [5-7]. Conversely, cultural norms may encourage pregnant women to consume specific items like cow's blood, sour milk, and ample water, and to induce vomiting after heavy meals. These practices are aimed at keeping the baby small at birth, thereby ensuring safe delivery for both mother and baby [5].

Adequate maternal nutrition—comprising sufficient energy, protein, vitamins, and minerals—obtained through a variety of foods during the "first 1,000 days" window is especially critical from conception through the first six months of life. It is vital for improving the nutritional status of both mother and infant and for reducing the risk of adverse birth outcomes [8, 9]. Poorly nourished expectant mothers are at a higher risk of preterm birth and of giving birth to infants with low birth weight and Intrauterine Growth Restrictions (IUGR), while also facing multiple threats to their own health and survival [10, 11].

The UN Office of the High Commissioner for Human Rights has stated that traditional cultural practices reflect the values and beliefs held by community members, often spanning generations. They have identified several harmful traditional practices, including various taboos that prevent women from controlling their own fertility, traditional birth practices, and nutritional taboos [12, 13]. In various studies, it has been noted that pregnant women in different parts of the world are compelled to abstain from nutritious foods as part of their traditional food habits [14].

Certain foods deemed inappropriate for consumption during pregnancy or lactation—such as spicy, malodorous, and nausea-inducing foods—are often eliminated from diets in countries like Burkina Faso, India, Indonesia, Nepal, Laos, and Senegal. High-nutrient foods are avoided during pregnancy based on a wide range of cultural taboos and misinformation [15, [16]. For instance, in Indonesia, 14 types of vegetables, 10 types of fish, 5 meat/animal-source foods, and 14 fruits have been excluded from the diet, as many believe these foods result in negative health outcomes for both mother and fetus [17].

In the southwestern and central regions of Ethiopia, pregnant women are restricted from consuming all foods that are white in color, such as milk products, fatty meat, porridge, and potatoes, based on the belief that these foods will be plastered on the newborn's body [18]. Additionally, it is believed that if a pregnant woman eats vegetables, both she and her newborn will emit a bad smell. In northern Ethiopia, high-carbohydrate and high-fat foods are forbidden for pregnant women under the assumption that these will lead to easier labor and smaller babies. Green peppers are also prohibited, as it is believed that newborns will become hairless as a result [19].

The major issue with food taboos is that they prevent pregnant women from accessing a well-balanced diet. Therefore, there is an urgent need to address the cultural practices that negatively affect the nutritional and health status of women. There is no doubt that maternal nutrition during pregnancy plays a crucial role in optimal pregnancy outcomes. Women in developing countries, including Ethiopia, suffer from nutritional deficiencies. However, sociocultural factors, including superstition and taboos associated with malnutrition, have not been thoroughly studied in our country or in the study area. This study will thus be undertaken to explore some of the taboos and myths among pregnant and lactating mothers in the Gedeo Zone, SNNPR of Ethiopia.

2 Methods

2.1 Study Area and Period

The study was conducted from March 25 to May 25, 2020, in Dilla Town, the administrative center of the Gedeo Zone in the Southern Nations, Nationalities, and Peoples Region. This town is located 360 km from Addis Ababa and 90 km from Hawassa, the capital city of the region. The total area of the town is 135 km², with a population of 102,624, which includes 50,286 males (48.9%) and 52,338 females (51.1%). The number of women of reproductive age is 20,204, and the total number of households is 20,944. The dominant ethnic group is the Gedeo, and most residents speak Gedeo-Offa and Amharic.

2.2 Study design

A community-based qualitative exploration study using a phenomenological approach was conducted. The phenomenological approach is a qualitative research method in which the investigator seeks to understand human experiences related to a phenomenon. This systematic and subjective approach highlights and explains lived experiences, aiming to give them meaning. Understanding these lived experiences characterizes phenomenology as both a philosophy and a method. In this process, the researcher strives to understand the experiences of participants on their own terms.

2.3 Population

All currently pregnant women and key informants residing in four randomly selected districts were the source population for this study. The selected districts were Bule, Dilla, Yirgachefe, and Gedeb. All currently pregnant women (in their gestational period of three months or more, as confirmed by self-report), lactating women who are currently breastfeeding children aged two years and below, and elderly women and men were eligible for the study. Respected elderly members of the community with known social status (e.g., religious leaders, clan/-community/ethnic leaders) who could provide relevant information on the topic were also eligible.

Additionally, 32 individuals were purposively selected as key informants for in-depth interviews. These included pregnant and lactating women, elderly women, elderly men, health extension workers, and religious and community leaders. A convenience sampling technique was used to select study participants with the assistance of community health workers and leaders. The recruitment criteria focused on participants' potential to provide valuable information about food taboos for pregnant women. Furthermore, a maximum variation technique was applied to include participants with diverse characteristics, such as educational status, residence, and age.

2.4 Data collection methods and tools

The study adapted an English version of a semi-structured interview guide from a doctoral dissertation by Samson Korvah Arzoaquoi titled "Common Food Taboos and Beliefs During Pregnancy in Yilo Krobo District, University of Ghana, Ghana, 2014." The tool consisted of the following sub-sections: 1) a list of foods considered taboo during pregnancy and the lactating period, 2) the adherence level of pregnant and lactating women to these food taboos, and 3) the reasons for adhering to these taboos.

The tool was then contextualized and translated into the local language (Amharic). Subsequently, two sample interviews were conducted in two other kebeles not included in the main study to pretest the tool for clarity and cultural sensitivity. The investigators conducted thirty-two in-depth interviews (IDIs) to gather further detailed information. Face-to-face interviews were carried out with the assistance of a translator using the IDI guide. Data were recorded using a tape recorder, and the investigators also took notes, including memos on participants' behaviors and contextual aspects, to ensure data triangulation. Each IDI lasted between 15 and 25 minutes.

2.5 Strategies for Improving quality

Credibility

Prolonged engagement in the research setting helped to collect more data across various ex-

periences. As a result in the credibility of the findings was enhanced.

Transferability

We used verbatim transcription to transcribe the data that assured data/thick description. Thus, this would allow others to determine the transferability of the findings to their situations.

Respondent validation

After transcribing the data collected, we presented the collected data to the study participants and confirmed their responses. The participants have given their witness to the finding.

Peer debriefing

After transcribing the data, one transcriber has checked the transcription of the others against the recorded audio. Then discrepancies were corrected.

2.6 Data processing and analysis

All in-depth interviews were audio-recorded, professionally transcribed verbatim, and cross-checked against the original recordings by the investigators to ensure accuracy. Data analysis was conducted concurrently with data collection and continued until data saturation was reached, defined as the point at which no new meanings or insights emerged from subsequent interviews.

The analysis followed an inductive phenomenological approach aimed at capturing the lived experiences and meanings of food taboos and myths during pregnancy. Initially, the research team repeatedly read each transcript to achieve immersion and gain a holistic understanding of participants' narratives. Meaningful statements and phrases relevant to food beliefs, practices, and perceptions during pregnancy were then identified and highlighted.

These meaningful units were assigned initial open codes that closely reflected the participants' own words and expressions (e.g., avoidance of spicy foods, restriction of sweet foods, fear of consuming "heavy" foods). Similar codes were compared across transcripts and iteratively grouped into broader categories based on conceptual similarity and shared meaning. Through constant comparison and team discussions, related categories were further synthesized into overarching themes that represented the essence of pregnant women's lived experiences regarding food taboos and myths. This analytical process moved beyond mere description to interpretation, allowing the research team to identify patterns, cultural meanings, and underlying beliefs influencing dietary practices during pregnancy. OpenCode software was utilized to support data organization and retrieval but did not replace the interpretive role of the researchers.

To enhance the credibility of the findings, member checking was conducted by discussing preliminary interpretations with selected participants to ensure that the themes accurately reflected their experiences. While the findings provide in-depth insights into food taboos and myths among pregnant women in the Gedeo Zone, transferability to other settings should be considered in light of contextual similarities in cultural beliefs and traditions.

2.7 Ethical Consideration

Ethical approval and clearance were obtained from the Dilla University Ethical Review Board. Official letters will be submitted to all relevant health facilities, and permission will be secured. Informed consent will be obtained from mothers by explaining the purpose of the study. Participation will be on a voluntary basis, and individuals who are unwilling to participate or who wish to withdraw at any stage will be informed that they can do so without any restrictions. Confidentiality will be maintained at all levels of the study by anonymizing participant names in the records.

3 Results

3.1 Socio-demographics characteristics

A total of 32 participants were involved in this study. Fifteen of the participants were Protestants, ten were Orthodox, four were Catholics,

and three identified as Orthodox. The educational levels of the participants varied, ranging from no formal education to a degree, with ages spanning from 18 to 66 years. The mean age of the participants was 35.5 years. Five participants had no formal education, ten had primary education, eight had secondary education, four were diploma holders, and five had attained a degree. All participants were married.

3.2 Codebooks

Spicy foods: foods that have hard , pungent and stronger flavor like green peeper.
Much foods: eating much amount of food than usual.
Sweet foods: From this study mothers call sweet foods , foods that are sweet in their taste and they listed foods like mango, avocado, papaya, banana, sugarcane, and sweet potato and honey.
Good foods: foods that are associated with the high-fat content

3.3 Food Taboos During Pregnancy in Gedeo Zone

The findings revealed that pregnant women in the Gedeo Zone adhere to multiple food taboos that restrict both the types and quantities of food consumed during pregnancy. These taboos are deeply rooted in community beliefs and are reinforced by elders, family members, and, in some cases, health extension workers. The taboos are primarily justified by fears related to fetal size, labor difficulties, and undesirable infant characteristics. Adherence to these taboos increases as women approach their due date.

3.4 Food Taboos Related to Fear of Large Fetal Size and Difficult Labor

A dominant theme across all interviews and FGDs was the belief that consuming certain foods or eating large quantities would result in an excessively large fetus, leading to prolonged, painful, and dangerous labor, including bleeding and even death.

Foods perceived as "fattening" or "good foods" were commonly prohibited. These included meat (especially "white meat"), milk, yogurt, and traditional dishes such as Doro wet. These foods were believed to promote excessive fetal growth.

A 66-year-old key informant stated:
"*Pregnant women should avoid eating meat due to it might make the fetus larger and it will cause difficulty of labor.*"

Similarly, a 32-year-old pregnant woman explained:
"*If I eat this foods it might stretch the stomach pushing the uterus resulting no space for the development of the fetus.*"

This belief was echoed by a 40-year-old Health Extension Worker (HEW) from Haroresa Health center, who reinforced community norms rather than biomedical guidance:

"*She should fully cease eating meat and other healthy meals, especially when she reaches the seventh and eighth months of her pregnancy... we encourage pregnant mothers to eat less and to eat dry foods like kolo.*"

The rationale extended beyond fetal size to labor complications. The HEW further explained that continued consumption of such foods would increase stool production, which was believed to prolong labor and cause bleeding.

A 35-year-old nursing mother from Dilla town added:
"*Women should avoid eating good foods like 'Doro wet' especially in the last trimester of pregnancy since it might cause an increase in stool production because it makes us very shameful at the time of labor.*"

Overall, the fear of labor complications strongly shaped dietary restriction practices, particularly in the later stages of pregnancy.

3.5 Restriction of Sweet Foods Due to Beliefs About Infant Weight and Development

Sweet foods were widely tabooed during pregnancy. Participants defined sweet foods as naturally sweet fruits and carbohydrate-rich items, including mango, avocado, papaya, banana, sugar-

cane, sweet potato, and honey. These foods were believed to increase fetal weight and cause delivery complications. Additionally, some participants associated sweet food consumption with adverse infant developmental outcomes.

A 25-year-old mother from Yirgachefe shared her experience:
"*During the time of my pregnancy I avoided eating sweet foods like avocado, papaya and banana... the baby was big so that I don't eat avocado and banana and other sweet foods.*"

Some beliefs extended beyond birth outcomes. A 28-year-old woman from Dilla stated:
"*If a pregnant woman eats honey while she was pregnant, the newborn may face problems like delayed speech development.*"

Similarly, a 60-year-old woman from Bule explained:
"*A pregnant woman should avoid eating sugarcane when she is pregnant because if she does so her child will be affected by excessive drooling.*"

These findings indicate that sweet foods were avoided not only due to fear of difficult labor but also due to culturally constructed beliefs about infant behavior and development.

3.6 Avoidance of Spicy Foods Due to Perceived Harm to the Baby

Another prominent taboo involved spicy foods. Pregnant women were discouraged from consuming spices such as *mitmita, datta, berbere*, and green peppers. These foods were believed to cause physical harm or undesirable physical characteristics in the baby.

A 38-year-old male participant stated:
"*Pregnant women should avoid foods that are spicy because those things might stick on the head of the baby and make him bald.*"

A 26-year-old mother from Yirgachefe similarly reported:
"*I don't eat spicy foods like green peppers, those things might cause pain to the baby.*"

A 42-year-old pregnant woman described how these beliefs were enforced within families:
"*Even if datta and other spices were my favorites I don't want my baby to be bald... it was my mother-in-law who told me these things so I do what she told me not to do.*"

These accounts highlight the role of intergenerational influence, particularly from elder women, in enforcing food taboos.

3.7 Limitation of Food Quantity ("Much Food") to Ensure Easy Delivery

Limiting the amount of food consumed during pregnancy was one of the most consistently reported practices. Nearly all participants emphasized that pregnant women should eat less and reduce meal frequency, particularly during late pregnancy.

A 57-year-old elderly woman stated:
"*Pregnant women should avoid eating too much foods because if the mother eats too much food while pregnant the fetus will get too big and she may face difficulty during delivery time.*"

Similarly, a 60-year-old elderly man explained:
"*Pregnant women should never eat too much food when they are pregnant because if she do so, she might go through difficult and dangerous labor.*"

A 29-year-old HEW reinforced this belief:
"*Most pregnant women in the area prefer to consume little food due to fear of big size fetus which may lead to difficult labor and also may lead to death because of bleeding.*"

Pregnant women themselves internalized these beliefs. A 27-year-old pregnant woman stated:
"*I during most of my pregnancy time I eat less food so that my belly won't get too big and fortunately my labor may be easier.*"

FGD participants collectively agreed that reducing food intake was necessary to avoid complications:
"*A pregnant mother should avoid eating much food during pregnancy because the fetus will not become large which lead to easy delivery.*"

Adherence to this practice intensified as women approached term. A 29-year-old pregnant woman from Gedeb town explained:

"*If a pregnant woman is in the last days of her pregnancy, she should decrease the amount of solid food items she eats to ease labor.*"

3.8 Social Enforcement and Authority of Elders and Health Workers

Food taboos were not individual choices but were socially enforced by elders, husbands, mothers-in-law, and even health extension workers. Elders were widely regarded as trusted sources of knowledge, and their guidance strongly influenced maternal behavior.

Additionally, some beliefs extended into lactation. A 52-year-old elderly man stated:
"*I believe pregnant women should avoid milk, yoghurt. Because if she do so the milk and yoghurt may make patches on the fetus head.*"

A 25-year-old lactating woman added:
"*If a pregnant woman eats milk and yoghurt, the fat will be patched on the head of the fetus thus the head skin of the baby becomes white in color when born.*"

These findings demonstrate that food taboos are embedded in a broader cultural system that governs maternal and infant health practices across the reproductive continuum

4 Discussion

The current study explored foods that are considered taboo for pregnant and lactating mothers and the reasons behind these practices in the Gedeo Zone. The findings indicate that pregnant women in this area are commonly restricted from consuming certain foods, particularly those perceived as nutritious. Similar practices have been documented in various parts of the world, where pregnant women are discouraged or compelled to abstain from nutritious foods as part of traditional dietary customs [5, 20–38].

Several barriers impede adequate dietary intake during pregnancy. In this study, foods locally regarded as "good foods," especially those believed to have high nutritional value, were frequently reported as taboo. These foods were avoided due to the widespread belief that their consumption can lead to excessive fetal growth, making childbirth difficult. Consequently, there is a strong community perception that a fetus should remain as small as possible to reduce the risk of prolonged, obstructed, or complicated labor. This finding aligns with studies from Kenya and other settings that report similar beliefs—that large fetuses are difficult to deliver and are associated with increased risks of episiotomy, obstructed labor, cesarean section, and maternal or neonatal mortality [39].

The avoidance of foods such as eggs, oily foods, meat, fresh milk, and cooked potatoes during pregnancy has also been reported elsewhere, where these foods are believed to cause excessive fetal growth [39]. For this reason, pregnant women are encouraged to eat less or to "eat down," a practice documented in several countries, including Senegal, Nepal, Laos, India, Japan, Pakistan, Indonesia, and Burkina Faso [33, 37, 38, 40–47]. Similar findings have emerged from the Afar region, Hadiya Zone, and Shashemene District in Ethiopia, as well as southeastern Nigeria, where women associate the consumption of nutritious foods with difficult deliveries due to increased fetal size [20, 27, 32, 41]. These practices may reflect limited awareness of the importance of adequate gestational weight gain and balanced nutrition for maternal and fetal health [51].

In the Gedeo Zone, animal-source foods, particularly meat, milk, and milk products, were commonly reported as taboo for pregnant women. The primary reason cited was the belief that these foods could lead to excessive fetal size. Additionally, some milk products, especially Arera and hot milk, were thought to adhere to the fetus's body and make the baby "dirty" at birth. Similar avoidance of milk and dairy products has been documented in studies from Hadiya Zone and Aballa District, where nearly half of pregnant women avoided milk and cheese (27, 48). Comparable findings have also been reported in Shashemene, Sudan, and Nigeria, where milk and fatty meat were considered taboo during pregnancy [32, 41, 49]. However, this finding contradicts evidence from Kenya, where pregnant women are encouraged to consume animal-

source foods like meat and milk to support fetal growth and maternal health [39].

Sweet foods were also restricted in this area. Pregnant women avoided sugarcane due to the belief that sugary foods cause excessive salivation and drooling in infants, while honey was believed to impair speech development. Similar beliefs have been reported in studies from Kenya, indicating that concerns about infant behavioral and developmental outcomes influence maternal dietary practices during pregnancy [39].

Spicy foods were another category commonly regarded as taboo during pregnancy in the Gedeo Zone. These foods were believed to cause pain to the fetus, stomach problems, or baldness in the baby's hair after birth. Similar findings have been reported in Nepal, where spicy foods were avoided due to fears of harming the fetus or causing illness [50].

Overall, the reasons for avoiding certain foods during pregnancy in this study can be categorized into three main themes: minimizing the risk of difficult and prolonged labor, preventing poor speech development and baldness in the baby, and avoiding skin discoloration in the newborn. Similar beliefs have been documented in Shashemene District of Ethiopia, where women believed that eating certain vegetables during pregnancy could cause skin discoloration by adhering to the fetal head during birth [32]. However, there is no scientific evidence to suggest that foods consumed during pregnancy can adhere to the fetus or cause abnormal skin color at birth, as neonatal characteristics are influenced by genetic, physiological, and placental factors rather than specific maternal food items [52].

Notably, religious reasons for adherence to food taboos were not reported in this study. This finding contrasts with evidence from Ghana, where religious leaders actively advise pregnant women on compliance with food taboos [11]. The absence of religious justification in the Gedeo Zone suggests that food taboos are primarily sustained through cultural norms and intergenerational beliefs rather than religious doctrine, highlighting the importance of community-based nutrition education approaches.

During lactation, mothers in this study avoided green vegetables and certain fruits, such as bananas, due to fears that these foods could pass through breast milk and cause abdominal pain in the infant. Similar beliefs have been reported in other settings, where maternal diet is perceived to directly affect infant gastrointestinal comfort [53]. However, evidence indicates that most maternal foods do not adversely affect breastfed infants, and unnecessary dietary restrictions during lactation may compromise maternal dietary diversity and nutritional status [53].

5 Conclusion

Foods considered taboo for pregnant women were found to exist in the Gedeo Zone. Pregnant women avoid consuming a variety of foods, including nutritious, sweet, and spicy items, due to fears that these will lead to excessive fetal growth, making delivery difficult; skin discoloration; and baldness, respectively. Additionally, lactating mothers abstain from eating green vegetables. Consequently, these food taboos could pose considerable risks for maternal malnutrition and adversely affect their offspring.

Moreover, many of these beliefs contradict the need to increase the frequency and diversity of food intake during pregnancy to meet heightened energy requirements. Therefore, strategic health communication is necessary to correct misconceptions, such as the beliefs that pregnant women should eat less, that certain foods cause diseases for both the mother and the fetus, and that some foods lead to skin discoloration in the fetus.

Abbreviation and Acronyms

ANC	Ante Natal Care
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
HC	Health Center
IUGR	Intrauterine Growth Restriction
NGO	Non Governmental Organization
PPS	Probability Proportional to Size
PRFT	Pregnancy Related Food Taboo

SNNPR	South Nations Nationalities and Peoples Region
SPSS	Statistical Package for the Social Sciences
TBA	Traditional Birth Attendant
UN	United Nation
UNICEF	United Nations Children's (Emergency) Fund
WHO	World Health Organization

Acknowledgments

Maternal and Child Health (MCH) clinics and Health Extension Workers (HEWs) should play a leading role in addressing food taboos identified in this study through targeted, context-specific nutrition counseling. During routine antenatal and postnatal visits, HEWs should actively screen for food taboos by asking women which foods they avoid and the specific reasons for avoidance. Identified misconceptions—particularly those related to fetal overgrowth, difficult labour, skin discoloration, poor speech development, and infant abdominal pain—should be documented and addressed through individualized counseling.

Nutrition education messages should be framed around the community's core concern for safe delivery, rather than dismissing local beliefs. For example, HEWs should explain that adequate and balanced food helps the mother gain strength for labour and supports normal fetal growth, rather than causing harmful fetal size. Beliefs that foods can "stick" to the fetus or cause skin discoloration should be respectfully countered by clarifying that the baby's skin and body are protected inside the womb and are not affected by specific foods eaten by the mother, while emphasizing that good nutrition supports a healthy baby and safer birth.

Pregnant and lactating women should be encouraged to "eat up" rather than "eat down," with clear guidance on increasing meal frequency and dietary diversity using locally available foods, including animal-source foods, fruits, and vegetables. Counseling should explicitly address commonly tabooed foods identified in this study (such as milk, meat, sweet foods, and vegetables), explaining their nutritional benefits in simple, culturally appropriate language.

Health education programs should also involve influential family members, particularly husbands, mothers-in-law, and elders, who often reinforce food taboos. Since religious reasons were not reported as drivers of food taboos in this community, interventions should focus on cultural beliefs and intergenerational knowledge rather than religious messaging.

Finally, MCH services should incorporate continuous follow-up to assess changes in dietary practices during pregnancy and lactation, ensuring that nutrition counseling is not a one-time message but an ongoing supportive process.

Data Availability

The data used to support the findings of this study are available from the corresponding author upon request.

Ethical Approval

Ethical clearance was obtained from Dilla University College of health and medical science Institutional Review Board.

Consent

Written consent was obtained from the study participants. Confidentiality and privacy were maintained during data collection, analysis, and reporting.

Conflict of interest

Authors declare that they have no conflict of interests.

Authors Contributions

RT, WM, SA and BG have contributed to the design, data collection, data analysis, manuscript write up and development, edition, and revision of the final manuscript. All authors read and approved the final manuscript.

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