

UNDERNUTRITION & MALNUTRITION A 'GENDERED ANALYSIS'

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UNDERNUTRITION and malnutrition due to limited access to food remain difficult and irreconcilable social realities primarily associated with poverty and limited purchasing power in the dominant discourse. However, as a development administrator, my field-level experiences reveal inadequate portions, erratic timings, infrequent meals, nutrient deprivation and insufficient food diversity within a household leading to malnutrition in children are often inextricably connected to the structural location of the person within the web of social relations and customary practices, and their local beliefs about the food they eat.

While biological and clinical causes of malnutrition within the germ theory are relevant, the social causation theory where latent cultural beliefs manifest in patterns of everyday consumption requires systematic analyses. The UN Sustainable Development Goal 2 to eliminate hunger and all forms of malnutrition by 2030, requires strong commitment at the granular level, where local institutions and community stakeholders including public health practitioners engage with communities as not 'beneficiaries' alone, but people rooted in their society's culture, oral history, power structures and philosophies that determines their everyday access to food. It also needs to be recognised that children and mothers, the target audience of every nutritional intervention, are entrenched within an institutionalised power structure.

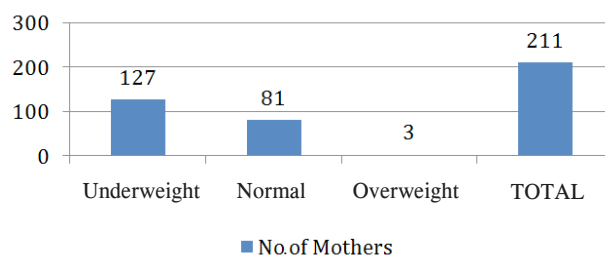
A significant pointer is the Take Home Ration (THR), introduced as a substitute to cooking and spot feeding at the ICDS centres in the backdrop of COVID-19. Despite the THR, the district of Purulia, West Bengal, recorded a high level of increase in the number of malnourished children indicating the unequal intra-household allocation patterns, where the child and her nutritional needs may get sidelined.

Setting the Context

To better understand the spike in cases of undernutrition and malnutrition, the household entailing the familial allocation patterns and social dynamics became a critical unit of academic and administrative curiosity. The household is embedded in a socio-economic and distinct cultural matrix, determining access to nutrition and *who gets what*.

While the issue of malnutrition has a robust biomedical base, latent cultural and social factors that are less visible but nevertheless push people towards undernutrition, also need to be examined. The author, in her capacity as an administrator, presents her findings of a study on latent cultural and social determinants of undernutrition and malnutrition in the Purulia District of West Bengal.

BMI Status of 211 Mothers of SAM Children



Of the 645 households of Severely Undernourished (SU) children in the Raghunathpur subdivision of Purulia District, West Bengal, 211 children were found to have Severe Acute Malnutrition (SAM) based on an intensive SAM identification programme. For children less than 6 months, weight and length measurements were taken, and for those between 6 to 59 months, height, weight, mid-upper arm circumference (muac) measurements were taken, with the nutritional status of the mother checked.

A social mapping exercise in turn anteceded the household survey. The 211 SAM households were disaggregated in terms of socio-cultural status. Of these, the Bauris, a Scheduled Caste community make up a sizable population of SAM households, followed by the Santhals, a Scheduled Tribe community, the OBCs mostly of Kurmis, and finally the Muslim and other households.

Research Methodology

While studying the existing socio-cultural practices amongst the Severe Acute Malnourished (SAM) households of the Raghunathpur Subdivision in Purulia District of West Bengal, 80 semi-structured interviews were conducted with mothers and family members of the SAM children in their local language. Six Focus Group Discussions were conducted with the mothers, to map food taboos and gendered practices, particularly for young women in their post-puberty and pregnant mothers. My community location, administrative reach and being well-versed in the Bengali language played an important role in determining access to the respondents.

Monotonous diets, lack of protein-rich foods and heavily starch/carbohydrate-based meals were found to be consumed by SAM households. A patriarchal social structure, where the mother-in-law and the eldest male member of the households played a more dominant role in resource allocation, was observed to be influencing the nutrition cycle of a woman's effective lifespan and also the child's.

Changing Cropping Patterns and Dietary Practises

A marked inter-generational transition was revealed in the existing cultivation and cropping pattern of the SAM households, affecting nutritional intake and consumption patterns. The quality of soil has deteriorated intergenerationally; from a diversified multi-cropping system of wheat, groundnut and sugarcane to presently a monocropping system of paddy cultivation. The produce, as a result, was not adequate or entirely appropriate for annual consumption leading to greater reliance on the local market.

Limited food and the lack of food diversity were seen as relevant factors in understanding supply-side bottlenecks. Small parcels of land that were at one time used to grow vegetables such as brinjal and green leafy vegetables by the earlier generation have turned fallow due to loss of soil fertility. Moreover, fragmentation of land due to family partitioning, and an increasing transition towards non-rural farm jobs, has led to increasing dependence on the purchase of food items from the local shops, rather than growing those.

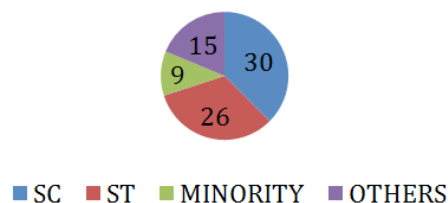
Many of the SC/ST communities find themselves in a culturally and socially transitional phase with changes and, with traditional dietary practices and cultural, customary preparations getting replaced by fast foods sold in non-descript local shops and grocery stores. The elderly of the SAM households commented on how the growing availability of urban (*shohorer jinish*) fast food is causing a lack of strength (*shokti komche*). Many parents of SAM children, especially in the case of boys, admitted to buying junk food such as chips and biscuits that are readily available in nearby stores and regarded such purchases as necessary, and even desirable to appease the 'stubbornness' of their boys. Consumption of such 'fast food' in several conversations with parents revealed how parents regard such food as an indicator of aspiration for higher status and a prominent element in their prestige and social set-up.

Food items that were earlier home-made, especially cultural cuisines such as 'pithe', 'payesh' and other sweetmeats are increasingly getting substituted by locally

available packaged foods and in some cases samosas too being purchased in mornings and evenings to be accompanied with tea. These fast foods with empty calories have aggravated the nutrition hiatus further.

This aspect of consumption the mothers however noted is also closely tied to the high workload and consequent time constraint of mothers, with rural women and especially those among the SC and ST communities, pursuing domestic work as well as income-generating activities/chores without any institutional support for childcare. The disproportionate gendered burden of domestic work and care often leaves mothers with little time to cook a proper meal in the morning for their children.

Survey Status of SAM



Dietary Patterns and Food Ideologies

Local beliefs about food affect everyday nutritional intake. The consumption of animal protein and eggs is found to be relatively less amongst the SC Bauris and the OBCs as compared to the General Category, the STs and the Muslims. The Bauris who form the predominant social and demographic group among the SCs, as well as among our SAM data, do not regularly consume eggs during pregnancy, with access to animal meat extremely limited. The mothers-in-law in many of the discussions informed how pregnant mothers ought to avoid consuming eggs, milk and certain forms of meat-based on local beliefs, particularly acute during the pregnancy and post-pregnancy phase of the mother. Local beliefs such as consumption of eggs causing eruptions on the face, milk aggravating mucus during cold, whiskered fish affecting the growth of the foetus, reservations towards particular forms of meat during certain seasons were revealed during the conversations.





A twenty-four-hour recall of food consumption in the households was used to determine dietary diversity. Most SAM households of this category consume animal protein including fish, eggs and poultry only once in 7-10 days, with mutton consumed rarely and only during festive occasions. The Bauri community consumes '*polltry*' (poultry) as a cheap alternative to other forms of meat or fish. However, it is curious to note that despite being cheaper and thereby more readily available as a source of animal protein, women in most families mentioned not favouring its consumption, with the fowl regarded as ritually 'impure' and dirty.

The Kaibartas of the fishermen community, another SC group, do not consume chicken on account of their worship of *Manasha Thakur* (local deity). However, while men of the family may eat chicken outside their homes, women cannot consume chicken. Women may not also consume snails (*googli*), such forms of meat being regarded as unclean and ritually impure. The Sunri, a SC community, do not consume pork as they regard themselves as '*laya*', a totem of the pig. However they consume goat and sheep meat, the animals being sacrificed (*boli*) in front of their deity. Many sub-tribes within the STs have their respective totems the meat of which is anathema and hence not consumed. The 'Haansdas' for instance are proscribed from consuming geese and ducks.

The Scheduled Tribes, comparatively, have a more diverse food basket in terms of animal protein (pork, turtle, rat, snails, birds, including duck and such waterfowl), but their transition due to an increasing sedentary life and rural transformation from a forest-based economy has led to certain culturally ambivalent dietary practises. Furthermore,

the dominant discourse on proper food, perpetuated by the higher castes that regard their food as worthless and '*aaje baaje*' (unclean and unfit for consumption) has created further confusion and a social ambivalence among the new generation.

Moreover, a variety of cultural beliefs which are prescriptive in nature, continue to surround the consumption of such diverse forms of meats and hence protein for women during pregnancy. Consumption of meat and certain forms of meat, in particular, is believed to orient the foetus and its growth to the energy and perhaps nature, and 'essence' of that animal. Thus an essentially diverse food basket for the STs too shrinks in the case of the mother during the course of conception and pregnancy. Babies and young children are not given eggs as their gullets are considered to be too narrow, with no particular cultural value attached to the consumption of eggs.

For the Muslim SAM households, '*mota mangsho*' – literally 'fat meat' (beef), is consumed frequently by adults and is far cheaper than other forms of meat, especially mutton. However, children are not served beef with the popular local belief that consumption would lead to the "brain becoming dull" (*mota mangsho khele buddhi bade na*), hence preventing cognitive development. It is also regarded as '*gorom*' (hot) with its consumption felt to be best avoided at a very young age. Other forms of meat, especially snails and those consumed readily by the ST community are regarded as impure and a food taboo. The SC community particularly the Rajwars and Bauris prefer not to give eggs and chicken to children that are believed to lead to flatulence and discomfort.

Raw tea or 'liquor' tea (*laal cha*) without milk and sugar is a regular hot beverage in the morning for most SC and ST SAM households, consumed both by adults and children. The beverage so taken has nearly no nutritional value in terms of energy or growth, and is taken with rice puffs (*muri*) or one dry chapati as an early morning refreshment. Milk as a food item is given less frequently. On enquiring, many families did not feel the need to continue giving milk after the '*Mukhebbhaat*' (rice feeding ceremony).

The morning refreshment is followed by the morning meal of '*Chal Shija*' or '*Maar Bhaat*', essentially starched rice and potatoes. '*Mota manush er mota khabaar*' (read, mota as crude; crude food for the crude individual), a common parlance among the rural working class, denotes the '*chal shija*' to be a no-fuss morning staple diet consumed regularly by children and adults alike. The potato along with the rice, regarded as an adequate 'vegetable' because it is filling, is consumed regularly with no diversification towards any other vegetable, not only because potatoes are inexpensive but also due to cultural reasoning of potato being 'heavy', 'bulk' food and hence filling, and will do for the day, without a thought for its nutritional value.

The morning meal is followed by a lunch of rice and very scanty vegetables with pulses rarely consumed, especially in the case of Santhals. The Kurmi Mahatos of the OBC category were in turn found to consume very little fish, eggs and chicken with their animal protein intake extremely low and relying primarily on a vegetarian diet.

In the case of almost all SAM households, barring the minority community, we notice an infrequent consumption

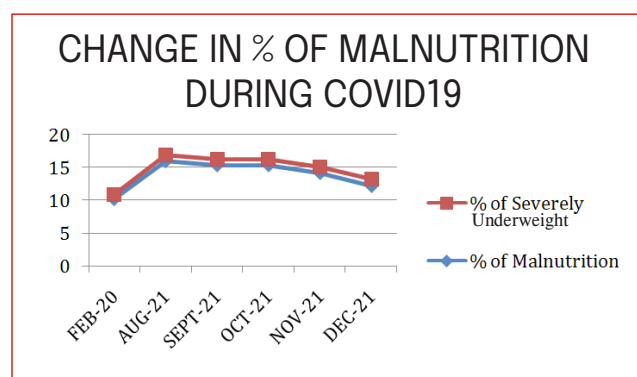
of animal protein, with only festivals providing the occasion for consumption of chicken and the less frequent red meat. Usually, festivals, cultural-religious events and the arrival of extended kinsmen (*kutumb*) create the context for more elaborate food preparation, with items such as *puri/luchi* (fried flattened bread), *suji halwa* (semolina sweetmeat) and meat products being more readily prepared. Pork is consumed by the STs during the *pous* (Mid Dec-Mid Jan) month on their '*Badna*' festival where pork pancakes (*suor er pithes*) are prepared.

Vegetables consumed include brinjal, tomato, papaya, saag and some seasonals like cauliflower and cabbage, but with very limited consumption. The vegetable basket is less diverse and quite limited in the case of the SC Bauris and the ST Santhals compared to the General Category and Muslim SAM households. Fruits are hardly ever consumed in these households, barring the day after fasting when it is considered a 'special' sort of food. In the Muslim SAM households, fruits and vegetables are more regularly purchased with many of the vendors regarded as kinsmen belonging to the same community. Dense kinship linkages leading to the possibility of purchase on credit were thus seen as serving a social cushion towards shocks of poverty and malnutrition. In fact, a common response in most of the SC Bauri households was '*dhare ranna*' (cooking on credit) indicating the socio-economic condition of precarious living with dense social ties to help them tide over crisis situations.

The social obligation for serving '*bhalo khabaar*' (good food), which involves the preparation of fish and meat, reserved for the extended kinsmen (*kutumb*) than the immediate family as custom for good order's sake, is indicative of 'everyday' food being neglected in terms of its nutritional content. Besides, expenditure is more readily incurred during the anticipation of a social obligation than the immediate nutritional care of the family, framed as oftentimes a 'luxury' that is best avoided.

COVID 19: Precariousness Exacerbated

When cultural preferences, biases and local availability converge with financial precariousness the combination can be debilitating in terms of access to nutritious and diverse foods for both children and women. Many households recounted having lost their livelihoods to Covid, with men of the households later working on '*kishti*' (credit) to pay off the loans that they had taken to meet household expenses and daily upkeep.



Detailed discussions with parents, especially the fathers of the SAM children, revealed how the loss of regular income and lack of sources of supplemental food from the ICDS centres, aggravated their already poor nutritional status. Those in the informal sector, particularly the daily wage labourers, have weathered socio-economic blows by cutting costs in a manner that reveals latent but severe consequences for household food insecurity, with children and mothers bearing the brunt of such cost-cutting exercises. Moreover, women of the household were noted to have taken up the additional task of informal labour and non-farm rural jobs adding to their workload.

Many SAM households confided in having shifted to cheap sources of calories, especially starch-based staples, reducing consumption of nutrient-rich fruit and vegetables and dairy products. The innocuous and inexpensive '*aloo jhol*' (potato gravy) dish cooked in almost all households, for instance, was cited as a very convenient dish, where a small quantity of potato is cooked in larger quantities of water to make more broth, even though watery, for better distribution among all family members. Micronutrient deficiencies are an inconspicuous but dangerous fallout of this.

Gendered Cultural Orientation

The mothers belong predominantly to an early age cohort of 17-23 years, with conception usually from the age of 18-20 years, indicating early marriage and early pregnancy, which in themselves are social and economic hazards.

The preference for sons is unmistakable with multiple pregnancies of mothers indicative of cultural aspirations and biases for a son, while the mothers continue getting girls. Village level social taboos, gossip, taunts and familial pressure operate in a potent manner to affect the reproductive choices and frequency of pregnancies of the mother, with disapproval from the affinal family and neighbours compelling the woman for conception, her (read the family's) social reputability being at stake. Common across most communities, with the STs as exception, labels such as '*atkure*' (pejorative connotation for a woman with only one girl child), '*teen betir ma*' (a mother saddled with three daughters), '*ajatta*' (devoid of 'jat'/social station) are part of rural parlance. Consider the statement of a mother, "If I die, it is fine, at least I will have a boy", reveals the tremendous social pressure within which a woman's sexual and reproductive choices are determined.

The in-laws home defines for many married women – who were interviewed particularly from the SC, General and other communities unlike the STs – a distinct social space, where hunger needs to be perforce regulated and repressed. '*Khide chepe rakha*' (literally suppressing hunger) is regarded as desirable. The natal home is regarded as a training ground for the affinal home, where virtues of temperance and patience can be taught, qualities regarded as appropriate for a daughter-in-law. By limiting their consumption of food in order to avoid disapprobation, women undermine their own nutritional status.

A 'culture of fasting' is deeply ingrained and internalised from a young age for the women of a household as something noble and pious, especially in the case of members of the SC Bauri and General Category, where the Manasa Puja, Kali



Puja, Durga Puja, solar and lunar eclipses, with as many as twelve fasts a year, serving as cyclical phases of tempering unbridled hunger and thereby ‘cultivating’ fortitude regarded as an essential feminine trait. These fasts are observed by women including pregnant mothers. The ‘*shrabon maash*’ (monsoon month) and the ‘*boishak maash*’ (stormy summer month) for instance is a month-long abstinence from non-vegetarianism, more readily practised by the women of a household.

For the Muslim mothers of SAM children, all were found to have observed the ‘Roza’ in their first and second trimester. A practice related to fasting is that of keeping a vow and abstaining from a particular food item, especially meat. Mothers of ailing children confided in keeping strict fasts on religious grounds (*manot or manshik*) which entailed denying oneself from a culturally valued food item. The culture of denial borne by mothers is not a chance occurrence but deeply rooted to gendered ideologies that find support in normative framework and are seen as a virtue.

The husbands in conversations appear to have limited roles in relation to their children’s nutrition, with most amongst the ST and even some SC communities, taking to alcohol in the evenings, adding to the woes of neglect of their wives. In some instances, the mother of the husband will also severely disapprove of her son’s interest and care for his wife, which compounds the apathy and neglect. More than 60 per cent of the households had household heads consuming alcohol.

The concept of self-care is an important measure for the imperceptible health of a woman, with most mothers agreeing to have no time to attend to themselves. Most health related initiatives of women remain focused on reproductive and sexual health care, but leisure and self-care often given a short shrift. “*Ghorei dome kaj, samay kothai pabo*” (with so much work, where would we get the time), *sansar er puro kaaj amake korte hobe* (I have to look after the sansar/domestic space) indicates the poverty of time.

Women, especially of the ST and Muslim community were found to be overburdened with the twin tasks of production and reproduction, with household chores of fetching water and cooking, to be managed alongside working in the agricultural fields, sometimes brickfields and performing manual daily wage labour, and childbirth. This lack of time for self-care in fact overflows to the domain of care for the child as well, with the household division of labour unfavourably tilted against her. The mothers-in-law and affines would in fact chide the mothers saying ‘*aage kaaj kore nao, tarpore baccha ke khawabe*’ (first finish your work, then feed the child)’. In fact many mothers mentioned government interventions such as the Nutrition Rehabilitation Centre to be obtuse to familial dynamics and the gendered burden of care, where having women stay for a length of time is a difficult proposition.

Household Food Allocation

A relevant axis of food allocation within the SAM households was noticed to be gendered, with culturally valued and expensive food items usually set aside for the men of the household, particularly sons/husbands and fathers-in-law.

A customary social practice, not without nutritional significance is the order and time of eating for the women and girls of the household. Eating last and not with the family, often means eating less and leftovers, affecting correct food intake, hence nutrition and thereby physical growth and cognitive development of the young women and girls.

Understanding food scarcity experienced particularly by women of the reproductive age in the context of symbolic power (Bourdieu, 1982) is thus instructive. Symbolic power or soft power includes quotidian acts that have discriminatory or injurious implications, but continue to be supported and nourished by existing social, historical, customary and institutional mechanisms.

A proxy indicator for such symbolic discrimination, regarded as ‘normal’ by existing customary practices is the order and time of eating. The Social Attitudes Research

for India (SARI) survey for instance and the India Human Development Survey (2011) regarded this as a key indicator for measuring discrimination. We are going a step ahead here to refer to this as symbolic discrimination, as the subject or the woman on many occasions accepts this as something ‘natural’ and even ‘desirable’, leading to an exchange of social values between her and her husband/affines. ‘*Ordhek peth*’ (half a stomach) was a repeated term by the mothers, especially of the Bauri SAM households. The feeling of shame ‘*lojja*’, to eat before the husband and the affines are deeply internalised by women of the SC, OBC and Muslim households, with hesitance and shame often coming in the way of accessing and demanding proper nutrition.

The grandmother of the child, being the mother-in-law, on several occasions would overtrump the voice of the daughter-in-law, especially when the latter would talk about her hunger pangs saying that these would have to be killed due to consideration of ‘feminine propriety’ in an affinal space *vis-a-vis* their natal homes. This cultural neglect of a biological need (hunger) is, however, ‘normalised’ by the mothers-in-law as quite natural and in keeping with feminine decorum.

The role of the father of the child during these conversations was in fact marginal, with many keeping away and often in an inebriated state, with the reins of decision making passed on to their mothers i.e. the mothers-in-law. The mothers-in-law in turn would admit during their own reproductive age to be keeping even more stringent fasts and going without food for days, especially post-pregnancy. As erstwhile victims of a patriarchal structure who now have a greater degree of security and autonomy, this condescension is uncanny and of a ‘patriarchal bargain’ (Kandiyoti, 1988) at work. In fact this condescension that is culturally and historically supported was observed in the tenor of the sisters of the husbands (sisters-in-law) as well, who referred to the daughters-in-law as ‘always hungry’, ‘greedy’ or ‘lazy’.

Socio-Cultural Perceptions – Impacting Women’s Nutrition & Childcare

A common theme determining a mother’s access to nutrition and child care practices is her cultural and ritual status within the household, tied to various life events connected to her body. The body of a woman is thus a bearer of multiple semiotic meanings, where her easy transition into becoming ‘ritually impure’ causes greater vulnerability in terms of her access to nutrition. In a patriarchal context, her bargaining power in turn is limited before the birth of the first child, rendering her decision making ineffective till she secures the status of a ‘mother’ and a child bearer.

A customary understanding, notwithstanding religion, is observed to be the tacit proscription towards consumption of meat products, fish and eggs during a woman’s menstrual cycle. The woman of the reproductive period is subject to a host of taboos and rituals, relevant in constructing gendered identities, with implications for her physical and cognitive development and that of her child. This is observed among the SAM SC Bauris and the Muslim households, but not so much among the General Category and the STs.

After conception, the mother and especially her womb, it is believed amongst some of the ST and SC communities,

becomes more vulnerable to supernatural sinister agents (*shoitan*), who may with their ‘*nojo*’ (evil eye) due to jealousy (*hingshe*) cause a condition commonly referred to as ‘*Gorbho Dosh*’ or, ailment of the womb. Her mobility is thus restricted, followed by dietary restrictions.

The natural/medical inability to retain food soon after conception is ordinarily seen as symptomatic of the ‘Dosh’. Constant vomiting and bodily discomfort is often culturally perceived to require intervention in the form of witchcraft, ‘*jhad phuk*’ or ‘*tuk tak*’ of community healers, shamans, magic men and witch doctors (ojhas/imams), commonly referred to as ‘*kakus*’ (father’s elder brother). The community’s reliance and confidence on such soothsayers exist alongside access to formal medical institutions, with the former often turned to in case of greater uncertainties and with no manifest ailments. Magical acts of spells with oils and water ‘*tel poda*, *pani poda*’, are still believed to cure the child of such imperceptible ailments. The lack of visible symptoms in fact leads to such cases often not being seen as a serious public health burden with no scientific monitoring thus making malnutrition as a disease even more precarious and hence a ‘silent killer’.

Micronutrient deficiencies and other forms of child malnutrition are silent diseases that culturally continue to be regarded as ‘weakness’ (*komjori*) rather than an actual ailment (*rog*). This cultural framing of a health hazard is not without its consequence. Not treated with a sense of urgency, early detection of ailments and treatment of children is usually neglected. It is only when malnutrition makes itself manifest in its worse forms that help is sought – that too more often from informal systems.

The phase of pregnancy and post-pregnancy are critical periods in which one observes restrictions and in some cases prohibition of ‘regular’ and ‘normal’ food, making it evident how these phases in the life cycle of a woman, though socially desirable, are not regarded as a ‘normal’ state of being.

The phase of pregnancy is a ‘liminal’ (Turner, 1974) phase for the woman, where her successful entry to the phase of motherhood is guided by a host of restrictions (*palon*), especially dietary. ‘*Palon kora*’, literally meaning to observe, was seen as the duty of the mother, the transgression of which would cause ailments to the foetus. ‘*Puni laga*’, a common local phrase to describe an infant born thin and undernourished, is believed to be a result of a mother’s transgression, particularly during pregnancy. The restrictions relate to her movements during eclipses (*grohon*), her code of conduct during auspicious and even malefic occasions and her dietary practises, putting her body and her nutritional status under strain. ‘*Ma jonta korbe, sheta cheler o hobe*’ (Whatever the mother does, the son would have to bear) indicates not only the cultural burden of reproduction but her eating, an act so mundane and seemingly private, entangled with the familial and the customary.

Mothers from the minority community too shared how during pregnancy they restricted their diet to ‘*bheja bhat*’ (literally soaked rice). During pregnancy mothers of the Bauri community mentioned not to be consuming eggs and snails, as these it is perceived would not be safe for the foetus.

The Murmu STs mentioned how pumpkin, otherwise a readily consumed and nutritious vegetable is avoided, as it

is believed the child would have a head as soft as pumpkin (*'bacchar matha kumror mto norom hoye jabe'*). Tudu STs for instance do not consume rat meat, an easily available source of animal protein normally consumed, as it is believed that the child would be born hairy (*'gaye chul hobe'*). Nor are other forms of meat such as the duck consumed as it is believed that the baby will have duck feet. *'Shudhu bhija bhaat aar ruti gorom thakle khetam'* (I would eat only rice and hot rotis).

The Bauri SCs mentioned how *'chorey/utha maach'*, meaning fish that rises due to excess water in the ponds, if consumed during pregnancy leads to constriction and spasms (*'khichuni'*). Whiskered fish (*'darir maach'*) is also avoided as the foetus is believed to develop autism and Downs syndrome. Eggs are locally believed to cause itching (*'khuji'*) to the foetus. The Mahatos forbid the consumption of snails by mothers, believed to lead to bubble formation (*'budi budi kata'*). The Mallik SCs, Rajwar SCs and Mahato Kurmi mothers mentioned how fish and eggs were forbidden for consumption with the belief that this may cause neonatal jaundice to the foetus. Mothers from the Rajwar SC community stopped consuming sour fruits, while consumption of snake gourd (*'jhinge'*), malabar spinach (*'pui saag'*) and kidney beans (*'shim'*) a readily available vegetable protein were discontinued based on local anxieties of such vegetables to cause genital abnormalities for an anticipated male child. Certain types of meats normally consumed, such as the pigeon (*'payra'*), snails (*'googli'*), turtle (*'kochhop'*) are also proscribed during this time. Hence, a less diverse and severely restricted animal protein basket.

The colostrum, which confers significant disease resistance to the breastfed infant, still continues to be regarded as an undesirable and in some cases 'ritually impure' secretion, with as much as 40 per cent of the SAM households, out of the sample, having a cultural diffidence towards its consumption, citing various reasons like drowsiness, loose motions and flatulence caused to the child. Despite institutional delivery, mothers noted how this thick yellow substance would not be fed to their infants based on familial consensus.

Normal delivery over caesarean was underscored repeatedly to be the most suitable preference, with the latter regarded as *'kharaap'* (bad). *'Sushto shorir ke besto kora'* (rendering unfit an otherwise fit body) is a popular Bengali cultural lexicon used for caesarean. To avoid this, many women admitted to having eaten less for fear of a 'bloated stomach' and weight gain leading to the possibility of caesarean. *'Pet hore khete ichhhe hoto kintu khetam na'* is a refrain and telling phrase where the mother expresses how she would feel like eating more but would restrain herself. The mothers also admitted to having stopped taking 'vitamins and Horlicks as they put it, meaning supplements and complementary nutrition, especially after 4-5 months so as to ensure that the womb does not grow further for fear of a possible caesarean regarded as costly and unnecessary. The development of the foetus is thus hostage to myriad beliefs and practices.

Yet another refrain, *'bachchaar shuye thaka uchit na'* (the child should not be lying idle or supine in the mother's womb), was common in the conversations. Hence, all work and household chores, it is believed, should be done by the

expectant mother, with some not being given even an hour's rest in the afternoons. Expectant mothers from the ST Santhal community in particular however acknowledged having done only *'halka kaaj'* (light work) though and taking some rest during pregnancy.

The post-delivery/postnatal stage, despite being a medically significant period, is apparently a culturally liminal/precarious stage, where the mother is made to observe certain dietary restrictions and food taboos before once again socially integrating with the family. The preoccupation with rendering the body 'dry' (*'gaa shukno'*) is distinctive, with most foods including meat and common vegetables like brinjal not being consumed.

While the duration of food restrictions is observed differently in different communities, ranging from 21 days to as much as 6 months, the restrictions are nevertheless salient with medical implications, especially for the child. The women from the Mallik community, an OBC/SC community, mentioned about not consuming fish from the date of delivery till the date of 'Mukhe bhaat' of the child, regarding such consumption to cause loose motions for the child by affecting the quality of milk. Eggs and fish were regarded as suspect, particularly by the SC communities, and best avoided as they are seen to cause skin eruptions and rash for the baby.

The mother, it was learnt, can eat only once during the day, and only *'shukno khabaar'* (dry food) at night if anything. This *'shukno khabar'* (dry food) it is felt would, in turn, make her body *'shukno'* (dry), regarded as a state that she needs to arrive at for the sake of the newborn baby. Some households, especially of the OBC Kurmi, were found to be exceptionally strict about the intake of food, with a very difficult fasting pattern observed with many new mothers having to consume *'dhane bheja jol'* (starch water). *'Tui jemon khabi, baccha ta shemni thakbe'* (the way you eat, that's how the child shall be) a medical fact, however, interpreted differently by different communities.

Every time foods such as rice, vegetables and especially fish and meat are suspended for a long period depending on subcultural beliefs and household dynamics. Consuming rice for instance by some of the Scheduled Tribes is believed shall lead to cough and cold for the child (*'Chele tar shordi hobe rate bhat khele'*). Meat products regarded as *'koda khabaar'* (hard food) are believed to lead to *'koda paykhana'* (hard stool) apparently affecting the quality of milk for the baby. The Kurmis, for instance, refrain from consuming eggs after pregnancy as mothers on the 21st day make offerings of eggs to appease their deities as *'sadh bhakkhan'* (local deity) during their *'ghat pujo'* where the deity is propitiated with offerings of sweetmeats and vermillion.

The 'Mukhe Bhaat' or 'Anna Prashan', rice eating ceremony amongst all SC, ST and General Category households, was observed to be at the age of 6 months for boys and 7 months for girls. The cultural reasoning offered is that a young girl needs to temper her desire and gluttony for food, and learn patience and endurance from an early age as she would have to display these qualities at her in-law's home. Also, since she was *'porer barir'* (of other's home). The reasoning that girls shall be 'denied' food at their in-law's house was also seen as a reason good enough to start them

grooming and socialising on learning patience, regarded as a feminine virtue.

Of interest is how this rite of passage for the child is complemented by often the mother's effective reintegration with the family where she along with the child starts taking proper food after her post-pregnancy restrictions. The mother can now re-enter her normal life.

Nutritional Intervention – The Way Ahead

Our study revealed various dimensions of food ideologies, proscriptions, prescriptions, food aversions and local beliefs related to not only consumption, but women's nutrition, upkeep, the concept of self-care, cultural perception of malnutrition, informal systems of healthcare, work, poverty of time and child care practises, with the intent of examining the culturally and socially resilient but less obvious factors that determine access to the quality of nutrition for the mother, and thereby the child.

Therefore, any nutritional intervention programme must appreciate the cultural and social determinants of malnutrition, where both the mother and the child, far from being independent entities on their own, are 'embedded' within a familial and highly patriarchal context of food consumption and allocation. Latent cultural beliefs and subaltern discourses that exist alongside the dominant medical discourse must be taken cognisance of as some may pose a serious challenge to governments, public health practitioners and development institutions' attempts to reduce the magnitude of malnutrition and undernutrition with their limited focus on only the biomedical aspects of it. Any form of advocacy and family counselling must address the subtle aspects of family customs and practices in a culturally sensitive manner. Being attentive to the distribution of power requires targeting the decision-makers within the families and households.

As an administrator and sociologist, I am interested in tailoring programmes and advocacy in a manner such that research and ground realities share a dialectical relationship. Based on my field interviews, study and conversations with the SAM households, I got in touch with the CSIR-Central Food Technological Research Institute (CSIR-CFTRI), Mysuru and entered into an MoU for conducting a pilot project in my sub-division. The project is being executed at the level of the Gram Panchayat, with identification of nutrition supplements, a weekly menu design, periodical monitoring of the nutritional status of the children and liaising with parents of SAM children.

I am also building on a communications outreach programme that can percolate to the Gram Panchayat level and involve our adolescent girls and boys as community change agents. Deep advocacy with local community agents and gatekeepers is critical in generating social consciousness about nutrition and the aspect of equitable sharing of the burden of care in their cultural space. 'SOHAG' (Sensitisation of Husbands and the Adolescent Groups), also a local phrase to refer to the care and affection of a husband, was thus a programme launched under my and my team's initiative, where we channelise masculinity in the positive direction by calling forth husbands to be responsible and empathetic participants in the nutrition and care of their wives and their children.



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