Unravelling Malnutrition

Challenges of a psychosocial approach

Report by
Barbara Weyermann

Based on research by
Gauri Giri, Sagun
Staff and volunteers, Sagun
Barbara Weyermann, *Terre des hommes*

Kathmandu, September 2003

Unravelling Malnutrition

Challenges of a psychosocial approach

Report by Barbara Weyermann

Action Research by
Gauri Giri
Barbara Weyermann
Staff and volunteers of Sagun

Kathmandu, 2003

For additional information please contact:

Barbara Weyermann
bweyermann@opsiconsult.com

Gauri Giri
tdhsagun@wlink.com.np

Terre des hommes
Mr. Michael Sidman
En Budron C8
CH-1052 Lausanne
msi@tdh.ch
004121 – 654 6666

Sagun
P.O.Box 7802
Kathmandu
sagun@harmony.wlink.com.np
009771 – 424 7920

Terre des hommes Nepal
Mr. Reinhard Fichtl
P.O.Box 2430
Kathmandu
tdh@mos.com.np
009771 – 552 9061

Table of content

List of Tables

List of Figures

Acknowledgements

A few years ago, when my first prospect of working in a psychosocial project came to me, I went to talk to psychoanalyst Paul Parin in Zurich. I asked him how I as a psychological layperson should support women who had survived the war in Bosnia and Herzegowina. He simply replied: Just listen to them and sometimes ask a good question.

Paul Parin's advice, of course, is hardly as simple as it sounded, but it has shaped my attitude since. And it has guided us in the action research that is presented here. Gauri Giri, a nurse and a community health specialist and I, an economist and development generalist, both had to make do with our common sense and limited knowledge we had about nutrition, health, economics, anthropology, sociology, psychology, and communication. All these fields are touched when we work with nutrition. We accepted early on that we could not be expert in everything and yet that we would have to approach malnutrition in an interdisciplinary manner. To that end, we tried to ask the right questions and listen to the field workers and families, and for everything else we sought the support of specialists.

Many experts helped us in our work. First and foremost, I would like to thank psychologist and specialist for psychosocial work David Becker of the Free University of Berlin for his patient backstopping of the action research process, for his provocative comments and precise inputs. Without his support this work would not have been possible. I also thank Martina Bungert, psychiatrist of the UMN Mental Health Program in Kathmandu, who supported us with her professional and culturally sensitive advice, as well as psychoanalyst Bettina Meier, Bern, who offered her interpretations of the emotional response of mothers in distress.

Many nutrition specialists helped us ask the right questions - I would like to thank Monique Beun, consultant; Amy Gillman, UNICEF Nepal; Dale Davis, UNICEF Regional Office for South Asia; and Ram Shrestha, Nepali Technical Assistance Group. I would also like to thank Patricia Engle, UNICEF New York, and Lida Lhotska, GIFA/IBFAN, for their comments on the research design and their encouragement to carry out the study. I am particularly grateful to Rebecca Norton, nutrition advisor of *Terre des hommes* in Lausanne, who provided us committed professional guidance and expertise throughout. I thank her for believing in our approach from the very beginning.

My thanks also go to *Terre des hommes* for supporting the development of the Urban Nutrition Project and for encouraging and funding this study. I would like to mention in particular Philippe Buchs, Chief of Program Department, Michael Sidman, Program Manager, and Laurence Vorpe, Program Assistant. Thanks also to Shilpa Lepcha, Program Officer at *Terre des hommes* Nepal, who helped me interpret the cultural context and my successor as delegate in Nepal, Reinhard Fichtl, who was always ready for inspiring discussions.

In Kathmandu, my thanks also goes to Sharda Pandey, Chief Nutrition of HMG Ministry of Health, Amir Khati, District Public Health Officer, and Dr. Babu Ram Gautam, Chief of Public Health, Kathmandu Metropolitan City for their interested and supportive attitude to our work.

The board members of Sagun graciously granted support to our research. Thanks to all of them and in particular to anthropologist Mukta Singh Lama and Kamal Phuyal, specialist for participatory development, for their valuable professional inputs.

The staff and volunteers of the Urban Nutrition Project were enthusiastic participants of this research. I would like to thank them all for their hard work and commitment and for their readiness to look at their work critically.

Most of all, my thank goes to my co-researcher Gauri Giri. I have come away from this project with the highest respect for her understanding of the dynamics at the grassroots and her commitment to the people she works with. I thank her for her creativity and patience and for her attitude of trying when others give up.

Finally, I thank Kesang Tseten for editing the report and for helping me unravel the many enigmas of Nepal. Without his intellectual and emotional support I would never have been able to do this work.

This study is dedicated to the mothers of malnourished children who allowed me to get a deeper understanding of what it means to be a woman in Nepal and what it could mean to be empowered. They taught me that development work, in spite of it all, has meaning.

Barbara Weyermann, September 2003

Unraveling Malnutrition – Challenges of a psychosocial approach
Executive Summary

The problem

Inadequate care is seen as one of the main underlying causes of malnutrition, besides inadequate household food security, the lack of a healthy environment and access to health facilities. Thus, a primary objective of many nutrition projects is to improve the knowledge and practice of good care. An array of factors determines how a child is looked after. Many studies have demonstrated that, besides the constraints of resources, the psychosocial situation of families is crucial. The complex psychosocial situation of caregivers of malnourished children often poses a problem for health promotion: A caregiver that is under great stress will not be able to provide patient care to children and is generally unable to absorb and apply the messages conveyed by the health promoter. Instead, the mother or father is likely to recount long and complicated stories of economic hardship and family quarrels. The health promoter will most likely view such narratives as a hurdle to imparting health education. If so, not much will happen, and the child will not improve. The health promoter, thinking she has put in a lot of effort in vain, might drop the family from the list of beneficiaries.

The fact that caregivers live with so much stress should not be viewed as an obstacle to health education but as a key to improving the health of the child. The better the family members are in coping with their problems, the greater the chance of the child's nutritional status improving. In a **psychosocial approach to nutrition**, meaningful health promotion thus entails working with the very specific emotional situation of a caregiver as it affects his or her ability to negotiate the family's socio-economic conditions and care for children. The socio-economic context defines the space the caregiver has to act. Thus, a psychosocial approach would not focus on improving the individual agency of the caregivers nor their social conditions; instead, it is a method rooted in the understanding of how these are interrelated.

The research questions

This study was undertaken with the aim of improving the health promoters' capacity to embrace a psychosocial approach. It is essential to have a better understanding of the situations and obstacles project staff must face, as a first step towards providing them a better support system. Our key research questions thus were:

1. Which psychological, social and economic factors are operative in families of malnourished children in Kathmandu?
2. What are the difficulties health promoters experience in trying to influence care practices at the household level?
3. How can the health promoter's capacity to carry out meaningful health promotion be improved?

The study context

The study was carried out in Kathmandu/Nepal between February and May 2003 with staff and volunteers from the Urban Nutrition Project. The project is implemented by the Nepalese NGO Sagun and supported by the Swiss Foundation of *Terre des hommes*. The project objective is to improve the Knowledge, Attitude and Practice of nutrition as it relates to women and small children. Health promoters, working together with the public health clinics of the municipality, carry out growth monitoring and promotion. The most important aspect of the health promoter's activities is home visits. The health promoters are female volunteers from the project area. The project is operative in seven wards of the city with a high number of migrants from rural areas and covers 21,000 households.

The study methods

The investigation followed the principles of action research and the methodology of "thick description." The problem to be analyzed demanded a qualitative approach because of the complex interlink of social realities and the very individual needs and capacities of the families and health promoters involved. The data was collected during regular interaction 1) between health promoters and families and 2) between health promoters and research coordinators. The period of the study was spread over four months, during which 22 health promoters regularly visited a family. Each of the 22 families of the sample had a child under 3 years that had not reached 80% of the standard weight/age. The families were selected at the last growth monitoring session before the research began. The visitors made a bi-weekly report to the research coordinators, following which they together decided on the course of action for the next visit. These cycles of visits and case review sessions allowed the validation of interpretations and interventions. Based on the narratives of the visitors, key issues were identified that were pertinent to the nutritional status of the children. The interaction between families and health promoters were discussed and analyzed. This led to the formulation of generative themes, i.e.,

political, social and economic issues that inevitably influence the nutrition status of children and the interaction of health promoters and families in the very specific context of urban Nepal.

Findings of the Study

Care practices observed in the study sample: Most care practices of the families in the study sample confirmed findings of other health and nutrition studies carried out in Nepal[1]. It was nevertheless impressive to observe that none of the 22 children visited in this study received adequate amounts of complementary food; further, none received appropriate care during sickness. Only 32% of the children in the study sample were exclusively breastfed for 5 months[2]. The rate of exclusive breastfeeding for Nepal is 59%. Whereas 77%[3] of mothers had taken iron/folate supplements during pregnancy according to a baseline survey done at the onset of the Urban Nutrition Project, only 23% of the women in the study sample reported taking supplements, and then too only occasionally. The low rate of supplement intake found a correlation in the equally low rate of antenatal check-up and hospital delivery (41% of the women in the sample delivered in the hospital as compared to 78% in the baseline survey).

Gender and other generative themes influencing malnutrition: Four generative themes that are socially, economically or psychologically relevant in the context of urban Nepal were identified as influencing the nutritional status of children. The most important of these four themes was the *position of women in family and society*. Mothers are viewed to be the main caregivers in Nepal. The role a mother plays in her family, the expectations that other family members have of her, and the support she gets from the father of the child or other members of the household were found to be crucial to the relationship she was able to form with her child. The relationship between caregiver and child is considered vital to the nutritional status of the child. This has been clearly confirmed in the study findings. Many mothers of the study sample were found to harbour highly ambivalent feelings towards their children. The underlying rejection of the child was generally rooted in autobiographical choices the mother had to make, given prevalent beliefs and values about womanhood and motherhood.

Another generative theme affecting nutrition in Kathmandu was the *inadequate household food security*. One third of the 22 families earned less than US$ 46 per month and struggled to survive.

[1] Ministry of Health, 2001 and 1999
[2] In Nepal, solid food is traditionally introduced at 5 months, on the occasion of the rice feeding ceremony in Nepal.

Another resource constraint affecting hygiene, and thus the nutritional status, was the *water scarcity* prevailing in many poor neighbourhoods of Kathmandu. The city only has half the water required during the dry season. Finally, parents were reluctant to bring sick children for treatment to hospitals and clinics. This *underutilization of bio-medical facilities* seemed to be connected to popular concepts of illness and healing. People often preferred seeking cure from shamans, tantric healers, and mediums. Apart from that, families bought drugs from the medical shop without consulting a doctor. Often, caregivers preferred not to go to clinics and hospitals because of the superior and disrespectful attitude of health personnel.

Interdependence of personal experience and social factors: Our case studies showed clearly that the emotional state of the parents and family dynamics influenced how the caregiver negotiated resource constraints. For example, a mother who didn't bring her chronically sick child to the hospital expressed her distrust of bio-medical facilities, but her action also stemmed from her ambivalence to the child. Focusing only on her motivation or on improving health services may not lead to the child receiving the necessary medical treatment. The same may apply to the situation of poverty. Caregivers of our sample failed sometimes to take advantage of the opportunities for making additional income presented to them. Thus, a precise understanding of how the personal and the social sphere interlink in a household is vital for any intervention to improve the child's health.

Relationship between health promoter and caregiver: A good understanding of the caregivers' priorities and motivation can be gained if a dependable relationship between family members and health promoter has been established. Only when the caregivers trust the health promoter will they reveal their situation or feel safe to reflect on it and to consider making changes. The study participants were surprised at how much time it took to build a trustworthy relationship. But they were also impressed by what could be achieved if they managed to overcome the obstacles that sometimes prevented them from really engaging with the caregivers.

Obstacles to effective health promotion: The main challenges to a successful application of the psychosocial method were found to relate to three issues: 1) the professional identity of health staff, 2) communication skills, and 3) the socio-cultural identity of the health promoters.

[3] 77% had taken iron/folate supplements but only 36% had taken it adequately, i.e. for the recommended duration and in adequate quantity.

Initially, most study participants found it difficult to accept that they had to listen to the caregivers to gain an understanding of their situation before conveying messages. That is because facilitating empowerment instead of dispensing drugs or advice contradicts *the professional identity of health staff*. Moreover, traditional health training for professionals and para-professionals put a priority on knowing bio-medical concepts and the content of health messages. Thus, health promoters are generally unfamiliar with the impact of psychological, social and economic factors on health and nutrition.

Another obstacle that arose in the interaction with the caregivers was the authoritarian communication style of many health promoters. This too was connected to their lack of basic communication skills (for example, in knowing how to conduct the crucial first visit, or how to effectively introduce health information). Often, though, the health promoter's recourse to doling out indiscriminate advice or blaming people for their own misery was a response to their own feeling of helplessness when confronted by a seemingly hopeless family situation. It was more likely for home visitors to avoid difficult emotions. When the caregivers told their stories, home visitors tended to concentrate on the technical or medical information and to discard or cut out the emotional information, as it related to the attitude to the child or the family dynamics. This stemmed from an analytical framework of malnutrition that focused on the technical aspects of care practices. Health promoters in Nepal, as in most countries, had never been sufficiently supported to understand and to consider their own emotions as well as the emotions of their clients.

The manner in which people communicated was determined to a large extent by the socio-cultural framework. The hierarchical social order tended to undermine a respectful attitude toward lower ranked social groups. The fact that female health promoters were engaged with mostly female caregivers, too, influenced the relationship they were able to form. Mothers and visitors were integrated into the same value system and, as women, often shared similar difficult experiences. This could foster a sense of solidarity in the health promoter, who might wish to support someone else with similar difficulties. Often, though, it triggered anger, fear or shame, and a need to distance herself when these emotions became intense.

Recommendations:

A psychosocial approach in nutrition focuses on the caregiver and his or her situation. The health promoters embark on a process to help the caregivers provide better support for her child's

development. As far as the capacity of health promoters working with the psychosocial approach is concerned, these can be strengthened with the following measures:

- Define the health promoter as a facilitator of empowerment
- Broaden the training curriculum of health promoters by including the impact of psychological and social factors on the nutritional status of children and the importance and dynamics of the relationship with the caregivers;
- Institutionalize regular case review sessions to deepen the understanding gained in training workshops and help health promoters to deal with their own reactions to the caregiver's situation.
- On a regular basis discuss and reflect with health promoters the implications of prevalent gender relations for the nutritional status of children and in terms of the relationship health promoters formed with the caregivers, particularly mothers.
- Address the generative themes with collective activities at the community level (for example, child care centres, lobbying for a fairer distribution of water resources and so forth)
- Create conditions for staff empowerment in the organization. If training workshops on participatory methods remain islands in an otherwise distinctly hierarchical environment, health promoters can hardly be expected to go into the community to facilitate empowerment. An organization or project thus should create conducive spaces for people to reflect their role and attitudes and to feel safe to try different ways of relation to each other.

Chapter 1 – Introduction

1.1 The loneliness of the field worker in the project

In a nutrition network meeting in Kathmandu, a programme officer presented her organization's successful project approach: the caregiver of a malnourished child participated in guided cooking sessions and learned health messages at the same time. After only a few such gatherings, the child's nutritional status went back to normal. At the end of the presentation, a field worker asked: And how many of these children relapse? The programme officer didn't know and we were too polite to pursue the question. The field worker was left to her doubts.

The field worker was only too familiar with the complicated realities on the ground. She knew that telling overworked or depressed mothers to feed adequate quantities of complementary food was often a futile exercise. But for some reason, experience such as hers tends to get lost in the process of programming for nutrition. Texts speak about "simple strategies to prevent infant and childhood illness" and the "need to strengthen the mothers' and families' capacities in these areas". When such programme-speak has to be translated into action by health promoters who deal with individual families, it often turns out not to be that simple. What if a mother doesn't show interest in changing her practices or if the child keeps getting sick without obvious causes for being sick? Then it is left to the field worker to find a solution or to drop the family from her list. The reports and graphs will set out to convince donors that all is well; but the doubts of these field workers will not appear anywhere.

In *Terre des hommes* Nepal, we shifted the focus of reporting: instead of stories of strengths and success we asked the health promoters for stories of

frustration and failure. For them it was a relief to have their difficulties being acknowledged; and for us programmers, hearing the tales of dysfunctional families or hopeless poverty and listening to the descriptions of the health promoters' helpless reactions was a reality check. Little is known or acknowledged by people working at our level in the development industry regarding the exact nature of the obstacles health personnel face when they are sent to strengthen the capacities of mothers and families to prevent infant illness and childhood malnutrition.

We thus needed to build better structures for supporting health promoters, to create spaces where they could talk about their difficulties. At the same time we had to improve the effectiveness of working with families of malnourished children. This meant that we first had to understand more precisely the conditions of these families.

1.2 Of depressed mothers and unwanted children: psychosocial factors in nutrition

The health promoters of the *Terre des hommes'* supported projects in Nepal are asked to strengthen the capacity of families so as to provide better care for their children. *Care* constitutes one of the three main factors that influence the nutritional status of a child, the other two being household food security and adequate health services and a healthy environment. *Care* refers to "the practices of the caregivers in the household which translate food security and health care resources into a child's growth and development"[1]. This includes breastfeeding and complementary feeding but also treatment during illness, for example, or protection from abuse[2]. Technically correct practices alone are not

[1] Engle (1997)
[2] For the full list of care practices see Chapter 4 and Engle (1997)

sufficient though. Children need adults who are capable of reacting adequately to their needs, communicating with them, encouraging their learning and protecting them from harm.[3] In recent years there has been a growing realization that the physical growth of children is intrinsically linked to how their caregivers relate to them. Consequently, many nutrition programmes presently seek to educate caregivers about responsive parenting[4].

Lack of knowledge, however, is hardly the only reason that prevents parents from extending good care. In nutrition projects in Nepal, we often observed that caregivers were not able to respond adequately to their children because they themselves were subjected to a lot of pressure. The reason for their stress was poverty, for example, or family quarrels. And "a caregiver who is experiencing depression or anxiety, or who is living under a lot of stress, will find it difficult to provide patient, loving care"[5].

Children react sensitively, and often with disease or malnutrition, to stress in the family, especially in circumstances found in developing counties, where an already precarious environment reinforces the negative consequences of any inattention.[6] Many studies have linked child malnutrition and problematic family dynamics. Dixon, Le Vine and Brazelton (1982) found a significantly higher than normal rate of illegitimate children and a high number of children that were cared for by people other than their mother in a sample of malnourished children in an East African village. In Uganda, Goodall (1979) also found a much higher number of unmarried mothers or family break-ups in a sample of children with kwashiorkor, compared to the control group of well-nourished children. Bouville (1993) observed that malnourished children in

[3] UNICEF (2001b)
[4] WHO (1999), Engle, Bentley, Pelto (2000); Engle, Lhotska (1999); WHO (1999); Engle, Ricciutti (1995)
[5] Engle (1997:30)
[6] Bossyns (2001)

Cameroon lived in a less stable environment than healthy children and Goodfriend (1999), observing such correlation in a hospital in rural Haiti, called for psychosocial pediatrics. In Nepal, a study was conducted that looked at the relationship between child health and the educational level of the mother. It revealed that schooled women had a cleaner appearance, spent more time with their children, and had children who were less stunted. When the level of emotional stress, according to a rating of the mother-in-law/daughter-in-law relationship, was taken into consideration, a different picture emerged: "In households where there are many family members and where the mother (of the child) does not have a good relationship with her mother-in-law, the stunting scores of the children of educated mothers are no different than those of uneducated ones."[7]

Such findings disprove the often held assumption that malnutrition in developing countries as opposed to malnutrition in the industrialized world is caused by "lack of knowledge or skills, rather than social dysfunction."[8] As a result, the question to be asked is: how can health education be effective if it is the psycho-social situation of the caregiver that prevents her from caring properly for the child?

1.3 Listening to mothers: a psychosocial approach in nutrition

Field workers tend to view the worries expressed by caregivers as an obstacle to an efficient delivery of health messages. They realize that the health education they provide isn't a priority for the family and will thus continue not to deliver results. In such an event, the health promoters often feel helpless and

[7] Joshi (2001)
[8] WHO (1999:18)

frustrated with the limitations of their efforts. To address this problem, we recalled the WHO-definition of health promotion as "the process of enabling people to increase control over, and to improve their health."[9] Thus, imparting health messages should not be the main objective of an interaction with a family; rather, the objective should be to facilitate the caregivers' empowerment to cope better with their situation. We made the assumption that only with a change in the family's psychosocial situation would the child's health have a chance to improve. It was to that effect that we defined the role of the health promoter: She should be a listener first and a teacher second.

This definition of the health promoter's role is in line with the well known principles of community education and it connects to psychosocial work with people that have to cope with social, psychological and economic stress in conflict and post-conflict areas. Development aid has in those areas clearly acknowledged that people have emotions and that these emotions significantly influence a person's ability to live, work and care. We believe that the principles of psychosocial work that are effective when dealing with survivors of human rights abuse and economic collapse caused by war can be adopted when working with people that have to cope with "normal" poverty and difficult social conditions.

According to psychologist David Becker, psychosocial work must be understood as a method rather than a specific activity[10]. This method implies a commitment to both individual people and their social context. The psychosocial approach in nutrition thus entails working with the very specific emotional situation of a caregiver as it affects his or her ability to negotiate the family's socio-economic conditions and care for children. The socio-economic

[9] WHO (1998)
[10] Becker (2001)

context on the other hand defines the caregiver's space to act. Thus, the psychosocial approach to nutrition does not only focus on the individual agency nor on the social conditions; instead, it is rooted in an understanding of how these are interrelated. If, for example, a mother doesn't feed her child five times a day because of her poverty and depression, the health promoter would first recognize that informing her of the benefits of adequate feeding frequency will not lead to a change of practice. The field worker would do better to focus on facilitating a process that allows the mother to gain hope and confidence and, subsequently, the ability to negotiate for income opportunities. The project, on the other hand, would acknowledge the relationship between poverty and malnutrition and facilitate activities at community level to address it.

Such a psychosocial approach is a challenge for health promoters. But their everyday experience tells them that the traditional form of message delivery often does not yield the expected results.

1.4 Goal and structure of the study

Sagun, the implementing NGO of the *Terre des hommes* - supported Urban Nutrition Project in Kathmandu, had been involved in a programme that adopted a psychosocial approach to nutrition for about a year when we decided to embark on this study. Our aim was to strengthen the capacity of health promoters in dealing with complex family situations. In order to design better support systems for staff and volunteers, we first needed to gain an understanding of the exact nature of the challenges they faced. The research questions are thus:

1. Which psychological, social and economic factors are operative in families of malnourished children in Kathmandu?
2. What are the difficulties health promoters face in influencing care practices at the household level?
3. How can the health promoter's capacity to carry out meaningful health promotion be improved?

The study was carried out in the setting of the Urban Nutrition Project in Kathmandu. This project, focusing on changing care practices and strengthening the capacity of public health clinics of the Kathmandu Metropolitan City is described in Chapter 2.

Our investigations followed the principles of action research. In Chapter 3 we explain the process and the methods of the research process. Staff and volunteers of the Urban Nutrition Project were at the same time subject and object of the study. We collaborated in analyzing the situation of the family they visited. But by these visits, the situation in the family had been influenced and changed. We thus analyzed, at a second level, the nature of the interaction between health promoter and caregivers.

In the interaction between families and health promoters, the care practices were discussed and assessed. In Chapter 4 we present these findings and compare the results with the largely quantitative baseline survey we carried out at the beginning of the Urban Nutrition Project.

What influences care practices? This is the central question that every effective health promoter has to be able to answer if she wants to make an impact. In Chapter 5 we identify the key issues contributing to the inadequate nutritional status of the 22 children in our sample and relate them to the generative themes

most relevant to the nutrition situation in Kathmandu. Our case studies illustrate how the main causes of malnutrition – gender, water scarcity, poverty and underutilization of health facilities – are negotiated at the household level, much dependent on the dynamics in the family and the caregivers' emotional circumstances.

In Chapter 6 we illustrate the psychosocial approach by presenting the detailed descriptions of two interactions between health promoters and caregivers. In both families, the children's recovery is closely linked to the caregiver's - particularly the mother's - growing ability to reorganize herself. The case studies demonstrate how the relationship of the caregiver and the health promoter created a space for reflection and provided a security for the mother to take the steps to change.

In Chapter 7, we identify key issues in the communication process between the home visitors or health promoters and their clients. Our conclusion is that the obstacles in health promotion and the facilitation of the caregivers' empowerment are rooted in the professional and socio-cultural identity of the home visitor as much as they are in the possession or the lack of communication skills.

Finally, in Chapter 8, we suggest how the project management can improve the support system for health promoters so as to achieve better results when addressing malnutrition at the household level. Essentially, our recommendations imply the need to broaden the training curriculum with the aim of imparting a more holistic understanding of nutrition and of the role of the health promoter. Equally important is the need to provide staff and volunteers the opportunity to deepen their understanding in regular case review sessions. These reviews will also lead the field staff to better understand their

own reactions to the caregivers. We suggest the institutionalization of such guided self-reflection because the individual history and social identity of a health promoter is as significant in determining the quality of her work as the knowledge she has acquired in training workshops. Social development is based on empowerment, not only of those we work with, but, equally, of the people who do the work.

Chapter 2 – Nutrition Work in the City

2.1 Introduction

The study was carried out with staff, volunteers and families of the Urban Nutrition Project, implemented by the Nepalese NGO Sagun and supported and funded by the Nepal office of *Terre des hommes*. At the beginning of the action research, the project had been operational for almost two years. In this chapter, we will introduce objectives and activities of the project.

The nutrition work of Sagun and *Terre des hommes* is carried out in an urban setting. The overwhelming majority of Nepalis still live in rural areas where most development efforts are concentrated. Kathmandu is regarded as having facilities, and most agencies do not see any need to invest efforts in the city. However, Kathmandu's population grew 60% in the last ten years to 1,096,865 in 2001[11] and within the city is found the widest disparity of wealth distribution in the country. The migration from the rural area is related to the increasing difficulties of eking a livelihood from the small plots of agricultural lands and, more recently, to the armed conflict between the Maoist guerilla and the army.

Later chapters will describe in adequate detail aspects of Kathmandu that are relevant to the work in malnutrition, Here, we will focus only on two aspects of the target population: the division between local and migrant population and the divisions between different castes and ethnic groups. Both categorizations inform interactions between people and have a significant impact on all issues discussed in this report.

[11] Central Bureau of Statistics (2001)

2.2 The Urban Nutrition Project

2.2.1 The project design

The objective of the project is to improve Attitude, Knowledge and Practice in relation to nutrition for pregnant women and children under 3 years in poor areas of Kathmandu. At the time of this research, the project was operating in 7 of the 35 wards of Kathmandu Metropolitan City KMC of which four were in the inner city and three on the outskirts of Kathmandu. The areas with a total population of 110,000 were selected in consultation with the Public Health Department of KMC and based on indicators that showed these wards as having a high influx of migrants from the rural areas.

The project concentrates on training volunteers as health promoters. The volunteers will reach out to their neighbours to improve their knowledge and practice of care for pregnant women and mothers of young children.

Sagun works closely with the ward clinics of the Public Health Department of KMC. These clinics conduct well-baby clinics and a very basic level of curative services. Sagun's efforts are aimed at improving the capacity of these public health facilities: growth monitoring and promotion, implementation of protocols for pregnant and postnatal women, family planning, and immunization.

The project entered negotiations with the Public Health Department in 2001 and also conducted the baseline survey "Knowledge, Attitude and Practice in Relation to Nutrition of Pregnant Women and Children in Ward 19 and 20 of Kathmandu Metropolitan City". The training of the first batch of volunteers and the capacity building of clinic staff commenced in October 2001. The project was planned to conclude at the end of 2004. The action research began 14 months after the actual start of the project.

2.2.2 The volunteers

Selection criteria: The selection of volunteers is based on door-to- door visits by staff and a short discussion with women about the programme. If a woman shows interest and decides that she has time to join the programme, she is invited to participate in the training. Sagun prefers women with small children who are of a similar social and economic background as the majority of the population in the neighbourhood. Sagun accepts literate and illiterate women; it has no preferences regarding how much education a volunteer has had. The staff avoids exponents of political parties in order not to party-politicize the project.

Training: The training of the volunteers includes 8 sessions of 4 hours each, with the training lasting 8 weeks. The training focuses on imparting basic information related to the nutritional status of children and pregnant and post-natal mothers. The curriculum includes sessions about child development and the impact of family dynamics on nutrition. The participants also learn PRA tools to explore their working area. The training methodology connects all inputs to the personal experience of the participants to show the relevance of the health information. The training is followed by regular follow-up sessions when volunteers are encouraged to bring up and discuss work-related problems.

The only financial incentive to participate in the programme is a remuneration of Rs.100 (US$ 1.30) per training day. This is in line with what most organizations in Nepal provide to motivate trainees to attend trainings. The regular "job" of a volunteer is not a salaried one. Sagun is keenly aware of the limited time volunteers have and designs the activities so that they do not occupy a volunteer for more than one or two hours every few days. Sagun knows that volunteers get demotivated quickly if they are required to do a lot of work without pay. Volunteers are thus assigned small working areas in their

neighbourhoods. Their charges typically include not more than 2-8 malnourished children and two or three pregnant women, but it also depends on the capacity and motivation of each volunteer.

Motivation: A volunteer's main motivation is the exposure to and gaining of new knowledge and the inducement of taking on a public role. Being associated with an organization, learning and being able to support neighbours are clear incentives as they enhance the volunteer's self-confidence as well as her status at home and in the neighbourhood.

Activities: At the time of our research, volunteers carried out monthly growth monitoring and promotion sessions at the ward clinics; they visited families at home and some had started to generate additional income by producing superflour, or "sarbottam pitho" as it is called in Nepal. Sagun also started small community-run child care centres in two wards where some volunteers found paid work and others helped occasionally in a voluntary capacity. Although Sagun doesn't consider literacy trainings as part of the programme, a few volunteers had the self-confidence and desire to start literacy classes for the many women in the neighbourhood who did not know how to read and write.

2.2.3 The staff

At the beginning of this action research, the project employed 11 staff, including the project leader. The qualification of the staff was as follows: 3 staff nurses, 2 Auxiliary Nurse Midwives, and one staff experienced in participatory development approaches. These formed the core staff. In addition, 4 Community Facilitators (CF) also joined the team. CFs received the same training as volunteers. Their capacity was further strengthened by their

participation in the regular staff discussions and internal trainings and by on-the-job training. None of the CFs had any kind of previous professional training.

Sagun organizes the work by ward: One core staff and one CF are responsible for all the work in one ward. This implies that all staff are involved in training, home visiting and in supporting the volunteers in their work. The advantage of this arrangement is that there is no division between administrative or office-based staff and field staff.

The management style of this project is participatory and the hierarchy is flat. This not only has the effect of deepening the motivation of staff but it also contributes substantially to the quality of the work. Psychosocial work is based on the ability to build relationships of respect and trust with people in the community. In the hierarchical society of Nepal, being able to relate to a person individually rather than as a member of a social category does not come naturally to professionals. If the staff are expected to act in a non-authoritarian, participatory manner in the community, they need the chance to learn and practice it in their own organization.

2.2.4 Sagun

The Nepalese NGO Sagun was founded in 1992. It is working mainly with marginalized communities with the aim to strengthen their capacity and access to resources. Since 1998, Sagun has been working in the urban areas. The initial project to improve the environmental conditions of health was carried out in two wards of Kathmandu. The Urban Nutrition Project has been initiated to address some of the major needs identified by these initial works in the historic city of Kathmandu.

2.2.5 Terre des hommes

Terre des hommes started its work in Nepal in 1985. Initially, the Swiss INGO concentrated on disability, mainly in cooperation with the Hospital and Rehabilitation Center for Disabled Children, besides working with women and dependent children in jail. In 2001, *Terre des hommes* Nepal started working in nutrition in one rural and one urban project area.
Internationally, *Terre des hommes* has a long tradition of working in health/nutrition. Presently, the organization is involved in this sector in 17 countries. In Asia, these countries include Nepal, Bangladesh and Sri Lanka.

2.3 Physical and social configuration of the project area

Kathmandu is originally a Newar settlement. The lay-out of the old city, of which a large part was constructed between the 13th and 18th century, reflects the socio-political order of the Newar. Their society has been and is organized along a very complex caste system. The Durbar Square with the old palace and important temples mark the centre of the old city. Around it live the members of the priest caste and nobility. In ward 20, which lies behind Durbar Square, we can still see how caste hierarchy dictated where different groups lived. The higher castes live nearer to the palace, the artisan castes somewhat away. The lower a group's rank, the closer it lives to the river. The "untouchables" used to live and are still to be found near the bank of the Bishnumati river, which used to lie at the margins of the city, and is as a crematory site associated with decay and death[12].

However, while the Newar still form a substantial part of the population, the migrants that have settled among them are of different ethnic and caste groups.

[12] Sagun, 2001 and Quigley, 1995

The salient feature of a Kathmandu neighbourhood is its social mix. Poor people may live on the ground floor while the landlord lives on the top floor of the same building. This social and economic mix has implications for the project, mainly requiring it to balance and often to resolve conflicts between groups that otherwise maintain separate social spheres. This is very well illustrated in the response of a youth club activist to our question of how many people lived in his chowk, the backyard around which the old buildings are ordered. He very confidently said: 150. When we asked whether he only counted the Newar population or included the renters, he reconsidered his answer. He was surprised that we would even think of including non-Newar residents. He subsequently changed the total population of his chowk to 370. The division between renters and locals is often reflected in their access to resources. For example, the local administration caters primarily to locals as they make up the voters, whereas renters are often registered voters in their locality of origin.

According to the baseline survey *Terre des hommes* and Sagun conducted in ward 19 and 20, renters made up 60% of the population. This distribution of the population between renters and locals is reflected in the status of the volunteers. Two thirds are renters and one third are locals[13].

A majority of the respondents of the baseline survey were Newar (45%), followed by Bramin/Chettri and by the ethnic communities of the Tamang, Rai and Gurung. About 7% of the respondents came from India and a small minority of less than 2% were Muslim. As the caste system is the broad framework within which social interaction takes place, we will briefly outline its logic.

[13] Sagun, Questionnaires to 76 volunteers in ward 20 and 35, 2003

2.4 Caste system

The caste hierarchy ranks people in accordance with the principle of pollution and purity. At the top are the Brahmin or priest caste and the Chettri or warrior caste. At the lower end of the totem are the so-called untouchables, artisan castes of the hills and Newar scavenger castes of the cities. In between are the other groups, as listed in the *Muluki Ain*, the National Legal Code of 1854.

While the democratic constitution of 1990 declares that the State shall not discriminate against citizens on the basis of religion, colour, sex, caste, ethnicity or belief, an amendment states that "traditional practices" at religious places are not considered discriminatory. In other words, Dalits or members of the "untouchable" castes are still not permitted to visit temples and shrines[14]. Social discrimination based on caste is a fact of everyday life in Nepal and is reflected, for example, in the gross over-representation of high-caste members in government positions or development jobs.

The Newar have their own very complex caste system. Additionally, some Newar are Buddhist and others are Hindu. Their priests are at the top of the hierarchy while sweepers and scavengers are at the bottom. The Newar priest castes contest the notion that they should be ranked lower than the non-Newar Brahmins. Also within the Newar caste system, there is scope for opposing views and conflicts over who is higher or lower between castes of similar status[15].

The ethnic groups or *janajati* have been assigned a place in the caste system by the ruling Brahmin/Chettri. Within their own societies, they have no such

[14] Gurung (2003)
[15] Gellner (1995)

Table 1: The five main categories of the caste system

(I)	Holy cord wearer (High caste Hindu: Brahmin, Chettri; Newar high caste)
(II)	Non enslavable alcohol drinker (Newar: Shrestha, Tuladhar, Maharjan and other Newar service castes; ethnic groups: Rai, Magar, Gurung)
(III)	Enslavable alcohol drinker (Tamang, Tibetans, other ethnic groups)
(IV)	Touchable impure castes (low Newar castes, e.g., butchers who in Kathmandu are often called Shahi; Muslims; Westerners)
(V)	Untouchable impure castes (Newar: Sweepers and Scavengers; Hindu occupational castes, e.g., tailors, metal workers, etc.)

Source: Hoefer, 1979

ranking but are differently positioned according to habitat, language and culture. They mostly speak Tibeto-Burman languages, and they are often Buddhists or some variation of animists and shamanists. However, the culture of the dominant group has had a significant influence on them in various ways, though the extent to which they subscribe to Hindu high caste values differs between groups and within groups, depending on their social and geographical position and their aspirations within a political and social system dominated by the high castes.

Generally, "caste defines certain groups in a hierarchy of ritual purity and pollution and prescribes intergroup behaviour in certain spheres, particularly marriage and commensality"[16]. Pollution in this context refers to ritual pollution and is not related to the Western secular idea of dirt and waste. Ritual pollution is connected to death, birth and miscarriage, and also to certain acts; to contact with objects such as metals, cooking utensils, soiled garments,

certain places and animals; ritual pollution is also connected to body parts (feet and sexual organs) as well as to bodily substances such as saliva, phlegm, semen and blood. Women and lower castes possess impurity because of their bodily impurities and/or "occupational impurity". The latter is related to their handling materials (metals, leather or excrements)[17]. Marriage between members of different castes is still rare and if a member of a high caste decides to marry someone of another caste, there are serious implications (see: Ramifications of an inter-caste marriage).

But central to the Urban Nutrition Project are the restrictions of who can accept what food from the other and who is allowed to enter whose house. People may hesitate or even refuse to invite those especially of the "untouchable" castes into their house. For members of the high-caste, it is sometimes impossible to enter the house of a low-caste person, though that is now less common in the city. Most volunteers said that they didn't mind visiting a low-caste person as long as they didn't have to eat in that person's house.

Food has a central significance in the caste system. Most castes have their own diet rules with certain foods that are taboo for them. Traditionally, a Brahmin would not eat pork or chicken or drink alcohol, whereas a member of an ethnic group would eat all these and drink alcohol. The caste specific restrictions regarding diet were not found to be a cause of malnutrition for small children or even pregnant women. There are enough items allowed in each group that can make up for the non-consumption of others. However, what is more of a problem for the project are the restrictions on commensality. The kitchen is the most sacred place in a house where purity has to be strictly maintained. Members of lower castes may be allowed into the house, but never into the

[16] Bennett (2002:8)
[17] Cameron (1998)

kitchen, if the family is orthodox. The caste rules also dictate who is allowed to accept food from whom. It is not surprising that one of the older volunteers who had otherwise no exposure to Westerners asked me to which caste I belonged and whether she was allowed to cook for me. Food can be polluted if it is handled by someone more impure than the receiver. Thus, only a Brahmin cook is acceptable to all other castes. Likewise, water cannot be accepted from the "untouchable" castes. While cooked rice cannot be accepted from the lower caste, ground rice can be accepted from everybody lower than oneself as long s/he is not "untouchable". Complex rules govern which food items can be accepted by whom and under what circumstances. And these restrictions influence the project activities often because volunteers or mothers encounter difficulties in mixing with members of other castes especially during meals. For example, the problem comes up during the training sessions for volunteers when they cook some of the recipes they recommend to families of malnourished children.

Many volunteers were markedly isolated and unexposed to different ways of thinking before they joined Sagun's training. One of the achievements and values of this project is that it offers women a rare opportunity to gain exposure and to interact with people of other groups. That represents a step in the long battle toward a less hierarchical society. The following example illustrates the magnitude of the task.

Ashmina Nepali: Ramifications of an inter-caste marriage

Ashmina (28) was in the first batch of volunteers Sagun trained in the fall of 2001. She showed exceptional motivation in participating in all project activities and was soon selected to become a paid Community Facilitator. Unlike most volunteers who do not matriculate from high school, Ashmina had passed her School Leaving Certificate, though she had never held a job. However, her easy adjustment to the working culture, her skills in dealing with people, and her intuition in

understanding elusive psychological factors influencing a family's situation astounded the project staff. It was hard to believe that she had been shy to talk to anyone before she attended Sagun's training: "In the past, I had the feeling inside me that I was all alone. I didn't have any friends, all the time I stayed at home. I felt I had forgotten how to speak to others. If anyone came to my home, I used to wonder how to speak, so I tried to avoid talking to that person."

Her insecurity and isolation can be understood in the context of her inter-caste marriage: As a high-caste Newar, she married an illiterate man of the "untouchable" sweeper caste. By this wedding, Ashmina became "untouchable" herself. Her family couldn't accept her marriage and severed all ties with her. They even moved out of the neighbourhood as her brother, who works in a project of a large development agency, said he couldn't stand seeing her face so often. Though she has been married for almost 10 years and has given birth to two sons, this has not changed: "Still, my mother and brother do not look at me. They are modern only on the outside, but at home they are very conservative. Not only because of the caste, but my husband is also illiterate and works as a sweeper, so they haven't accepted me yet."

Initially, Ashmina lived in the house of her in-laws. As the house didn't have its own water supply, she had to stand in line at the public water tap. If she happened to touch another vessel, the owner would publicly and angrily pour the "polluted" water on the ground. The pot had to be cleaned by a special ritual. Finally, she couldn't stand it any longer and switched house with her sister-in-law who lived in a low-caste area. Her sister-in-law moved back to her parents' house – for her, Ashmina explained, dealing with the daily humiliation was easier as she had never known anything else.

Ashmina never openly regrets her decision to marry her husband, but her ambivalence is apparent. "I was very innocent, I didn't know anything…we didn't know each other very well, we just met and it took on its course, it wasn't even love." About her husband Ashmina said: "He was never encouraged to study because there was this mindset that even after studying he would remain a sweeper. So, he remained uneducated." She believes that the taint of low caste could be reduced by schooling since society places an enormous value on knowledge and education.

Ashmina says that low-caste people avoid contact with higher caste people for fear of being insulted. She recalled an episode when she and her sister-in-law went to a party of a higher caste friend. When they were noticed by other guests, one woman got very angry and shouted: why do you bring such people to the house, now we cannot eat here. "Our own friend had to ask us to go and eat outside."

We asked her how her originally being of high caste affected her. She smiled embarrassedly: "I now suffer what I used to do myself." She described how she had to take her friends who were of a lower caste out to the courtyard to eat and how she had to purify the plates they ate on with fire after they left. She knows well how deeply repulsed high-caste people feel when caught up in interactions they perceive as polluting. She is dealing with complex contradictory feelings: while regretting her decision to give up her caste she is now forced to question her former values; while taking a clear stand against the treatment of low caste people, she may also feel resentful that she is humiliated undeservedly, given that she was of a different caste by birth.

The exposure she gained from the training and the recognition she gets through her work have boosted her self-esteem. Her status vis-à-vis her husband and in-laws has risen. Her husband has taken on some of the household work and his family asks her regularly to their house whereas, before, they too hadn't accepted her. In the neighbourhood, many people seek her advice. Also, for her it is vital that the project leader Gauri Giri encourages and supports her staff to skillfully challenge caste consciousness. Whenever Ashmina is part of a training team, she serves the snack. It is left to the participants to eat it or leave it. Only rarely do they reject the food with some excuses. A Brahmin volunteer, Ashmina recounts, initially never asked her to enter her house. But as the friendship between the two women grew, the volunteer was able to overcome her traditional reaction and Ashmina now feels comfortable about visiting her. A fellow Community Facilitator was shocked when she first heard that Ashmina was an "untouchable." After they worked together for a while, though, she invited her home. Ashmina declined, saying that the colleague's mother-in-law may not accept her coming in. The project leader, however, encouraged Ashmina to accept such invitations. Being herself of high caste married to a Dalit, she conveys the conviction that one has to overcome this self-demeaning behaviour: "If people know who you are and still invite you, you have to accept, if only out of self-respect."

It was touching to hear Ashmina's enthusiastic account of the Bartaman bhoj, the initiation of her son into caste and patriline: "Everybody came to my house, so many people came!" She mentioned three high-caste men from the neighbourhood who she knew through her work. She said that she was so happy she couldn't help thanking them again and again for coming.

Chapter 3 – Research Process and Methods

3.1 Methodology

This study was carried out on the basis of the paradigm of action research. Action research is usually qualitative, participative, reflective and cyclic[18].

The problem to be analyzed in this study demanded a qualitative approach because of the complex interlink of social realities and the very individual needs and capacities of each family or home visitor. The complexities cannot be adequately measured or understood by quantitative methods.

The research coordinators and the home visitors met regularly to assess the process of home visits and what was happening in and to the families. The process of data collection was connected to the process of common reflection of the home visitor's actions and search for solutions. The conclusions arrived at from this process were assessed based on the experience of the home visitors at their next meetings with the families. These were reflected upon again and the interventions adjusted.

The research coordinators documented minutely each meeting they had with the home visitors. The aim was to form a *"thick description"* of the interactions between the families and the home visitors as well as between the home visitors and research coordinators. The term *thick description*, coined by anthropologist Clifford Geertz, describes the layered and contextual description of an event or social scene. A description in the sense of Geertz reflects "the said"; it is interpretative and microscopic. *Thick descriptions* yield facts to think about - in relation to mega-concepts"[19]. The connection between the individual narrative and the larger categories relevant for nutrition was

[18] www.mcb.co.uk/imc/coursewa/doctoral/bobda.htm
[19] Geertz (2002)

established by using the concept of the "key issue" and "generative theme", based on Paulo Freire's framework for community education (Freire 1973), as well as "the situational approach" (Zimmer 1976), an educational concept developed in Germany.

We used these concepts linked to community education because the main task for the home visitors was to help the families improve nutrition practices for their children. The experience in community education shows that people are capable of integrating knowledge if the knowledge is related to their personal situation and helps them gain better control of their own lives. In order to find out how knowledge can become relevant for people, we have to know more about their lives and their central problems as these will influence the nutrition status of the child.

The health promoters or home visitors as we also call them in this report went to see the families every week over four months. They tried to understand the family situation in general as well as the issues related to nutrition, such as care practices. In the narrative of the family members, *key situations* emerged. Key situation*s* are events that condense a combination of relevant personal dynamics of caregivers, the socio-economic factors influencing the family situation, and cultural beliefs and values.

The home visitors, supported by the researchers, identified and decoded *key situations* pertaining to the families. As the home visitors reported their visits to the researchers, *key situation*s of the interactions between home visitors and families, too, were identified and decoded. These *key situation*s reflected a condensation of the home visitor's personal experience, her feelings, and her

Table 2: Objective and Process

Objectives of the study

To understand

- the psychological, economic and social factors influencing malnutrition at household level in Kathmandu
- the difficulties of health promoters to influence care practices in individual households

To recommend

- strategies to improve the effectiveness of health promoters

Research process

22 health promoters visit one family weekly

Bi-weekly review of visitor's narrative, decision of what to do next; applying it in the family; assess effect of intervention in next case review session

Identification of key issues and generative themes
for families and for interaction between families and visitors

Time Frame for action research

February to May 2003

values and beliefs regarding community and the relationship between members of different groups, for example**.** The purpose of identifying and discussing such *key issues* was to enhance the capacity of the home visitors to engage the family in a more empowering dialogue.

From *key situation*s that define each individual situation – in each family as well as between the family and the respective home visitor – *generative themes* were distilled. These indicate the underlying issues leading to many similar *key situations*. *Generative themes* are politically, socially or psychologically relevant to the given context. The *key situation*s and *generative themes* identified were used to formulate an analytical framework that could be the basis for improved training and support methodology for the project.

3.2 Organization of the research process

3.2.1 Sample of families visited

The study was conducted in Sagun's Urban Nutrition Project described in chapter 2. In this project, families came regularly for growth monitoring and promotion sessions. In the session immediately preceding the start of the action research, families to be visited were identified according to the following criteria:

- Child is below 80% of standard weight/age (WHO)
- The family has not been home-visited before by any person associated with this project.
- The mother has not participated in one of Sagun's groups for mothers of malnourished children.

These criteria were to ensure that the visitors would gain a picture of the situation not yet influenced by interactions with the project.

From among the children who came to the growth monitoring and promotion session preceding this study, the ones who were underweight and had not had any previous contact with Sagun staff or volunteers were randomly selected

and assigned to staff and volunteers. The composition regarding gender and caste/ethnic group was accidental. Girls were clearly over-represented in our sample as compared to the gender distribution in the project. But the distribution according to *jat* (ethnic group/caste) was similar under the project:

Table 3: Gender of malnourished children

	Sample	**Project**
Girls	77% (17)	58% (236)
Boy	23% (5)	42% (168)
Total	100% (22)	100% (404)

Source: Sagun

We do not think it problematic that the boys were underrepresented in our sample. As in all nutrition projects in Nepal, the Urban Nutrition Project covered more girls than boys, and the larger number of girls in our sample gave us greater insight into the dynamics in families of underweight girls.

Table 4: Ethnic group/caste of malnourished children

Jat	**Sample**		**Project**
Brahmin/Chettri	8	36%	41%
Tamang/Rai/Gurung	9	41%	25%
Newar			
High-castes	1	5%	8%
Low Castes	2	9%	6%
Other low castes			
Indian groups/Muslim	2	9%	19%
TOTAL	22	100%	100%

Source: *Terre des hommes* and Sagun, 2001

3.2.2 Monitoring of weight development

The children selected for this study were weighed monthly and the weight was plotted in the "Road to Health"-card, issued by the Ministry of Health of His Majesty's Government and based on the WHO standard. The growth development was one tool in the analysis of the child's status. It also provided feed-back on whether the home visits improved the situation. For this study,

the children were weighed 5 times, once before the visits started and 4 times in the course of the home visiting process.

3.2.3 Medical screening of children

The children in the sample were screened by a medical doctor, the screening organized by Sagun. This was not planned initially as the project design foresees that if children do not improve for two months, the caregivers are sent to the hospital for screening. The clinics in the community lack facilities for checking blood, stool and urine. When we realized how hard it was to motivate the caregivers to go for screening to an appropriate medical facility (see chapter 5), we organized the screening with a reliable doctor. Of the 17 children screened, 8 children were without symptoms and 9 were diagnosed as follows: Two anorexic, one with pneumonia, three with cold and cough, two with diarrhea, and one with a urinary tract infection. The malnutrition (as per modified Gomez classification) of 13 children had been diagnosed to be moderate, three were severe and one was mild. Five children of the sample were not brought for check-up. In one case, this was connected to the family's failure in taking the appropriate measures for their child's improvement, which constituted part of the "pathology" of this family. In four other cases, the families did not turn up because they either had urgent commitments or didn't find the place.

3.2.4 The researchers
3.2.5 .1 Home visitors

The total sample of home visitors was 47. The home visitors were of different backgrounds and the quality and intensity of the interaction between them and the research coordinators varied.

Out of the 47 visitors, 22 were seen bi-weekly over 4 months by the two research coordinators. The sample of 22 included:

- **5 Project core staff.** They worked as the project's training facilitators and as coach for volunteers and home visitors between 2 years and 3 months before the start of the research. All of them had been working in other organizations before they joined the project. Two were staff nurses by profession, two were Auxiliary Nurse Midwives and one had no health background but many years of experience in participatory development methods and training.
- **4 Community Facilitators**. They were paid as Sagun staff though they worked less regularly than the other staff. They lived in the community and supported volunteers in organizational matters and generally in community activities. They also carried out home visits. None of them had any professional background. They attended the 8 sessions of the nutrition training for volunteers.
- **13 volunteers.** Volunteers in Sagun's projects live in the neighbourhood of the families they visit. Their educational background varies, with some that are illiterate, and others that have studied beyond the School Leaving Certificate. The volunteers in Sagun's projects are of different social and economic background. As volunteers, Sagun selects women who have children and whose socio-economic circumstances approximate that of the majority of the people in the

neighbourhood in which they will serve. For this study, we selected volunteers who had demonstrated interest and motivation to work after they had completed the training sessions. All but one volunteer in our sample were literate. Two had School Leaving Certificates and the others had attended school for varying periods of time. None of them had ever attended a training before they came to the Sagun training for volunteers. Seven volunteers were from ward 35 and 6 from ward 20.

3.2.4.2 Research coordinators

The action research process was coordinated by Gauri Giri, project leader of Sagun's Urban Nutrition Project and by Barbara Weyermann, former delegate of *Terre des hommes* in Nepal. Gauri Giri is a nurse with more than 18 years of experience in community health and in training of professional and para-professional health staff. Barbara Weyermann is an economist and development generalist and had been working with psychosocial projects in other parts of the world.

3.2.6 Schedule of interaction between home visitors and researcher coordinators

These 22 visitors were assigned the family nearest to their own house and were supposed to visit this family once a week over 4 months.
The research coordinators met with the project staff (core staff and CFs) on a one-to-one basis every two weeks for the duration of 90 minutes each. The staff members first reported on what had happened in their meetings with the family. The report about the visit was supposed to be as detailed as their memory would allow. There was no guideline as to how they should report, but they were encouraged to describe the interactions between family members

and visitors and between caregivers and children present. They were asked to describe their observations of the physical environment, the house where the family lived, the atmosphere, among other things. Following their description of the visits, research coordinators and visitors began to identify *key situations* in the family and also in the process between the family and the visitor. At the session's end, a plan was made regarding the interventions in the next meetings.

The research coordinators met the volunteers in two groups of 6 and 7 for 3 hours every two weeks. Here, the focus was less on the exact narration of the visits but more on the interaction between visitors and families and the difficulties faced. Still, *key situations* were identified for the families but more in the foreground were the *key situations* between the visitor and the family.

To verify the findings described in these group meetings, an additional 25 volunteers were selected to participate in two group meetings of one day each. In these meetings, we discussed the experience of the participants with home visiting in relation to the *key issues* and *generative themes* that had earlier been identified with the volunteers we met regularly. During these group discussions, we cross-checked our findings against those from the more in-depth process with the other 22 visitors.

3.2.7 Focus Group Discussions

To check and enrich our understanding of the context of the case studies, we also carried out two Focus Group Discussions with volunteers of two different ethnic groups. The participants of one group belonged to different Newar castes while the other group included volunteers belonging to the Tamang community.

3.3 Confidentiality

The basis for this research was the relationship of trust we were able to establish with staff, volunteers and caregivers. In order to present our case with the supporting data, we will recount the stories told to us in the process. We have, however, changed names to protect the participants and ensure confidentiality.

Chapter 4 - Care Practices

4.1 Introduction

When the home visitors went to the families, they usually first looked into the care practices. UNICEF's Care Initiative defines care practices as "the major activities performed on a day to day basis by caregivers which affect the nutrition of women and children…Care for nutrition refers to the practices of caregivers in the household which translate food security and health care resources into a child's growth and development. These practices include 1) care for women, including care for pregnant and lactating women, 2) breastfeeding and complementary feeding, 3) psycho-social care, 4) food preparation and food hygiene, 5) hygiene practices, and 6) home health practices"[20].

Care for mothers and care for children are closely interlinked and the degree of support a mother receives directly influences her ability to provide care for the children. In relation to care for mothers, we have in this chapter focused only on whether she received medical check-ups and supplements during pregnancy and lactation and also where she delivered. The following chapters will look in greater depth at the much broader picture of how she is supported in her role as a mother and how her capacity to care is affected by that.

The Urban Nutrition Project and this study generally follow the definition of care practices as suggested by the *Care Initiative*. However, we have changed the terminology of **3) psycho-social care**. What Engle in the *Care Initiative*[21] refers to is an attitude to children: responsiveness, attention, affection, encouragement and protection from harm. Listed are some specific activities

[20] Engle (1997:23-26)
[21] ibid.

such as the encouragement of playing and exploring and protection. But other important elements such as frequent interaction, adapting the caregiver's behaviour to the child's development level, and so forth, proscribe an attitude to the child that influences every care practice and every interaction with the child. We would, therefore, suggest replacing the term "psycho-social care" with the term "stimulation and protection". This category includes the encouragement to explore and learn and the protection from harm and conditions that are unfavourable or disturbing for the child (e.g. long separations from familiar caregivers etc).

In this chapter we describe the care practices included in the list of practices which the project intends to improve. We will compare what the visitors found in the 22 families they visited over 4 months with the results of the quantitative baseline study undertaken in 2001[22] before the start of the Urban Nutrition project. At that time, the sample was 304 and included not only malnourished children.

4.2 Care for women

The Urban Nutrition Project focuses on care during pregnancy and lactation. But as only two of the 22 mothers in our study were pregnant, we did not specifically focus on the care practices during and after pregnancy. The visitors, however, asked the mothers about that period in order to understand the history of the mother and malnourished child.

4.2.1 Care during pregnancy

Only half of the 22 mothers went for ante-natal check-up during pregnancy; however, three made only one visit. This result is significantly worse than the 88.5 % that said they went at least once for check-up in the baseline survey.

While in the baseline survey, only 23% said they never took iron/folate tablets during pregnancy, in this study it was 64% (14 out of 22). This discrepancy is related to the attendance figure for ANC. If they didn't go for check-up, they would not have known they should take supplements.

Six mothers told the visitors that they occasionally ate additional food during pregnancy. The other 16 did not eat more while they were expecting their youngest child. This is in line with the findings of the baseline survey.

4.2.2 Delivery

While in the baseline survey only 22% of the respondents said they delivered at home, in our study it was 59%. We assume that the baseline survey results were too optimistic. As it is known to happen in such instances, respondents may have said they delivered in hospital because they assumed that the stranger who came to their door wanted to hear this. Sagun's experience in training volunteers confirms that this often happens. After several training sessions women sometimes corrected their initial statement that they had delivered in a clinic or hospital, which is considered modern and representing higher standards than delivering at home.

[22] *Terre des hommes*/Sagun (2001)

4.2.3 Care after delivery

Only two mothers went for post-natal check-up and only three took iron/folate tablets after delivery. Of the 9 mothers who delivered in hospital, only one remembered having received Vitamin A. This is in line with the baseline survey result. The maternity hospital in Kathmandu claims that they give Vitamin A routinely, but the mothers do not remember taking it.
Twenty out of twenty-two women rested two months or less after delivery, and nine of them less than one month.

4.2.4 Low birth-weight babies

A baby is considered low-birth weight if s/he weighs 2.5 kg or less at birth. Of the 22 babies, 13 were born at home. We do not have the exact weights of these children at birth, so we asked the caregivers how the baby looked. Their response seems to have been based on their comparison to other children in their communities or families. Our findings are thus not based on precise measurements but on the caregiver's impression or perception.

Eight of 22 or 36% of the caregivers said the baby had been small or very small at birth. In Nepal, low birth weight babies count for 30% of all babies born. The difference to the national average is smaller than can be expected from a sample consisting only of malnourished children.

4.3 Care for children

The children in our sample were between 9 and 33 months old when the home visitors first met the families. The caregivers, when asked why their children were underweight, said that their children didn't want to eat or that the children

were always sick. Two mothers said they couldn't understand why their child was underweight.

4.3.1 Breastfeeding

Breastfeeding is universal in Nepal. Every mother who can starts breastfeeding her child and, according to custom, breastfeeds exclusively until "pasni", the rice feeding ceremony at which a girl at five months and a boy at six months is given solid food for the first time.

Although the WHO standard for exclusive breastfeeding is 6 months, and the Ministry of Health of HMG Nepal also recently introduced this standard, the Urban Nutrition Project considered it acceptable if children were breastfed for five months exclusively in accordance with the custom of "pasni". The baseline survey showed that 97% of all women initiated breastfeeding and 64 % breastfed exclusively for 5 months. For Nepal, the rate is 54%[23]

For this study, we found that only 7 out of 22 - or 32% - of the children were breastfed exclusively for five months. Colostrum was given to all but three children, two of whom were never breastfed at all.

Less than half of the 15 mothers who didn't breastfeed exclusively long enough didn't know any better. Three mothers couldn't keep to the customary 5 months because hospitalization or family circumstances led to long separations between mother and child. Two mothers had to go to work after two months. And four mothers were so stressed by their family conditions that they were not able to produce milk at all or not for long.

Of the 16 children under two in our sample, 88% were still breastfed, in keeping with the baseline findings. It should be noted that in Nepal children are often breastfed until the next sibling arrives.

The visitors observed that children didn't stay on the breast long enough. Mothers put their children to the breast each time the child needed comfort or expressed a wish to be fed, which resulted in very frequent, short periods of breastfeeding. The children often drank breast milk just before regular meals and thus had little desire to eat solid food.

4.3.2 Complementary feeding

At the beginning of the home visiting process, none of the children in the sample received enough food. When the visitors did a 24-hour-recall of the food given to the child, they found the gaps between meals, in all cases, to be too long and/or the amount fed inadequate.

Many children ate "food from the shops" between the meals or they were sometimes given dried instant noodles or "puff", pastries of layers of flaky pastry without fillings rather than a meal. But the nutritional value of such "junk food" was too low to make up for the inadequate amounts eaten during the two to three main meals of rice, dal and vegetables.

Difficult eaters were usually not actively fed but, instead, the mother often seemed resigned to the fact that the child didn't want to eat. Children who don't have a healthy appetite are more difficult to feed. And the greater the difficulty in feeding a child, the more the caregiver's impatience and sense of rejection may grow. We observed this in three children who a doctor diagnosed as having anorexia. One of these mothers was often frustrated and cursed her

[23] HMG Ministry of Health (2001)

18-month-old daughter for being a difficult eater. She expressed these feelings to the visitor: “The older children grew like buffaloes, without any problems. But this girl was born to give me trouble.” In “The Care Initiative” Engle (1997) writes: “When anorexia is a problem, caregivers need to actively encourage food consumption, particularly for the child under three. But that means ensuring that caregivers have the time, knowledge, resources, self-confidence and support to encourage anorexic children to eat.” Most important, we should add, the caregivers should really desire their child’s improvement. That was, in our observation, not really the case with one girl in our sample who was discriminated in her family because she was a girl (Sita Thapa, chapter 5).

4.3.3 Stimulation and Protection

Family members often do not have the habit of consciously playing with children or talking to them. The mothers we met believed that small children did not understand what was going on around them or that stimulation was not required to support a child’s development. One family had given their 7-month-old boy a traditional mixture of herbs to make him sleep throughout the day so he wouldn’t disturb the mother busy doing the work for the joint family. When the visitor explained that caregivers needed to play with children and to talk to them, the women in this family seemed surprised and asked: “What to talk to children about?”

Most mothers were not aware of the impact of leaving children alone over long periods of time. One mother, however, attributed her child’s diarrhea and frequent crying to her long absences while running errands when the child was a few months old. She described the symptoms of her child as a result of a state called “sato gayo” – loss of soul. This is described by the volunteers as a

common affliction of children who suffer a fright[24]. The lost soul can only be brought back by a dhami, a traditional healer.

"Sato gayo" was a common diagnosis of children's sicknesses but usually it was connected to the impact of a sudden fright and not related to long separations from the caregiver, for example, or to the effects of violence and abuse in the family or against the child. The effect of such family conditions was not viewed by mothers to account for a child's failure to thrive.

Older children often tend to be physically disciplined, while very young Nepali children are usually not. This was confirmed in our study. We didn't find evidence of physical abuse, though, one mother said that she sometimes beat her 2.5 year-old daughter. The mother had become a widow when her child was only 45 days old, and had been finding it difficult to cope with the economic hardship resulting from her husband's death. She told the visitor that there were times when she was so frustrated and angry that she came back and hit her daughter.

This pattern was also found by Sagun trainers when they talked to mothers about the dangers regarding the abuse of children. Many said that they hit their children as a deflection of the shabby treatment they received from other adults, e.g., the mother-in-law. One mother said that she would hit her children to be rid of her anger. When asked if it would not be better to target her anger

[24] In her anthropological study of tuberculosis, Kristivik (1999) confirms this view and explains the concept: "Loss of soul is a state of critical imbalance and confusion in a person, caused by a separation between the physical body and the *sato*, which roughly can be translated as soul, or life force….A person's *sato* is what makes a person's speech coherent, forms the characteristics of a human being (..) and gives a person his sense. Losing one's *sato* means losing the ability to orient oneself and account for oneself. It leads to extreme confusion and 'mad behaviour', and is a life threatening condition….Children are prone to lose their *sato* if they go through a sudden fright (tarsine). A child who has lost its *sato* cries all the time, does not want to eat and gets diarrhea…..the concept is associated with miserable babies who do not gain weight. In adults it is usually connected with mental disturbances." (p. 52)

at the real source, she said: ”How can I loose face by getting angry at my mother-in-law?” On learning about the negative effects of abuse on children, the training participants were very intrigued. They had never considered that beating could have such implications. At the end of the training course for volunteers, many mentioned the session about abuse of children as particularly important for them.

4.3.4 Home health practices

All children in the study suffered regularly from cold, cough and diarrhea. Over the four months these children were visited by staff or volunteers, everyone of them was sick at least once. The majority suffered from episodes of sickness once or several times per month.

No caregiver in the study was aware that feeding had to be continued during a child’s sickness and that it was important to feed more when the children recovered. They also rarely gave additional liquids. Most mothers reported that their child didn’t want to eat at all during sickness. All of them drank breast milk, at times nothing but breast milk.

Only half of the mothers said they took the child for check-up to a clinic or hospital before giving the child medicine. Instead, many mothers brought their children to the healers and/or to the medical shops. Visitors observed that children were given drugs often in inadequate quantities, which is problematic when the drug is antibiotics. We will come back to the vital issue of treatment during sickness in Chapter 5.

4.3.5 Hygiene practices

The levels of hygiene varied greatly between the visited families. Comments about inadequate hygiene came usually very early in the narrative of the visitors about their families. This had to do as much with the visitor's discomfort in having to deal with very dirty children or sitting in dirty rooms as with the impact the hygienic practices, or their lack of, may have had on the nutrition status of the child. While 6 out of 22 visitors said the room and/or the mother and child weren't clean, 11 reported the surroundings of the house in which children played as being dirty.

One third of the mothers did not wash hands before handling food. And no mother had given her child boiled water before she was visited. The children in this study were not alone in drinking unboiled water; virtually everybody in the community does. For us, it was a *key situation* when we asked the 7 volunteers of ward 35 during a meeting for this study whether they boiled their water. All of them said they did not. "Boiled water," they explained, "does not satisfy the thirst." They didn't like the taste of boiled water. Yet, in spite of their own practice, the visitors dutifully asked the mothers to boil and drink only boiled water. Some caregivers said the extra expense for kerosene fuel discouraged them from doing so. And when a visitor reprimanded one mother for not giving boiled water - though her son suffered from frequent diarrhea - she replied: "His older brother drinks the same water but he does not get diarrhea." The fact is, water is highly contaminated in Kathmandu, but her reasoning is still worth a consideration. Some children got diarrhea while others, eating and drinking the same food and water, were more resistant. We treated such differences in the family or between families as an indication that we should look deeper for the underlying causes of a child's failure to thrive.

4.3.6 Vitamin A supplements

All the children in our sample received the high-dose vitamin A/deworming capsule that is distributed twice a year under the National Vitamin A Programme. This result is even better than the 81% coverage indicated in the baseline survey.

4.3.7 Immunization

Twenty out of 22 children were fully immunized in accordance with their age. One child of 11 months had still not been given the measles shot and a child of 26 months who had just arrived from the rural area was not immunized at all. This result is not surprising. The immunization coverage in Nepal is high[25].

4.4 Conclusions

The practices we found in our sample of malnourished children showed that, indeed, teaching families how to care for women and children is vital. Inadequate complementary feeding and care during sickness was found to be a key issue in all 22 families: None of the caregivers kept feeding the children during sickness and none of their children in this sample received enough complementary food.

Otherwise, the care practices in our sample only deviate significantly in the following areas from the practices we found during the quantitative baseline survey carried out two years ago in the same area:

[25] BCG-83%; DPT I-83%; DPT II-77%; DPT III-71%; Polio I-97%; Polio II-96%;Polio III-93% and Measles-64% according to the HMG Ministry of Health (2001).

- Ante-natal check-up: only 50% of the mothers went for ANC compared with 88% in the baseline.
- Iron/folate supplementation during pregnancy: Far fewer women in our study had taken supplements during pregnancy.
- Hospital delivery: significantly more mothers in our study said they had delivered at home.
- Exclusive breastfeeding: Only 32% as compared to 64% in the baseline survey said they breastfed exclusively up to five months.

These differences may be explained by the errors that are inherent in quantitative surveys. If not enough time can be spent with caregivers it is often impossible to find out what the respondents really do and what they say to please the interviewer.

Chapter 5 – Underlying causes of malnutrition in Kathmandu

5.1 Introduction

After the visitors had assessed the care practices for the malnourished child, they tried to tell the family different ways for improving it. But they soon realized that communicating the "correct" message didn't bring about any change. Only in two cases did the child show quick and continuous weight gain when the mother understood that she had not given enough food to the child. In both families, the causes of the child's failure to thrive were eliminated: Both mothers had been living in rural areas and were unable to feed their children adequately because of their heavy workload. Now, in the city, they spent much of their time at home and thus only needed to know how to increase the feeding frequency for their children to bring about improvement. In all the other cases, however, the visitor's attempt to teach the family improved practices did not show immediate result. So the question can be asked: Beyond the lack of knowledge, what guided the families in their care for children?

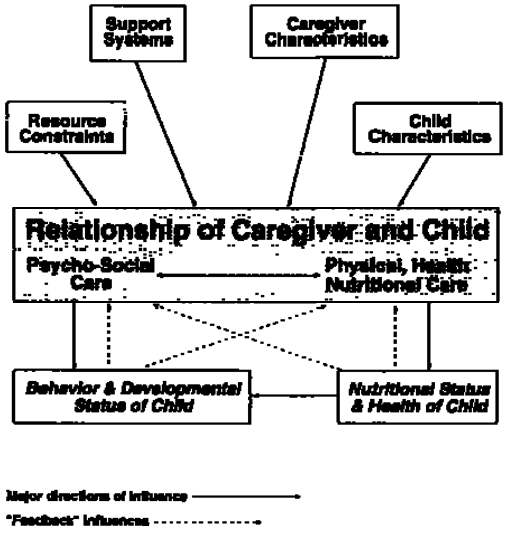
Many factors influence a child's ability to thrive, but our case studies showed that the central issue is the relationship between the caregiver and the child. This confirms what Engle and Ricciuti (1995) described in their article "Psychosocial aspects of care and nutrition" (Fig.1)

Using our case studies, we will illustrate how this relationship of caregiver and child is shaped by resource constraints, the availability of support for parents, and the individual characteristics of caregiver and child. In this chapter, however, we will also show that there is a hierarchy between these factors. In

Kathmandu, as in South Asia[26], this hierarchy is defined by the generative theme of "the position of women in family and society." It is the social definition of womanhood and motherhood that greatly influence the development of personal characteristics of caregivers and the relationship of family members with each other.

These family dynamics and individual characteristics in turn mediate how resource constraints are handled and affect the nutritional status of the child. The material we

Fig.1: Factors affecting the relationship of caregiver and child[27]



analyzed in the process of this action research showed that resource constraints in Kathmandu can be mainly defined as "water scarcity," "inadequate household food security," and the "underutilization of health facilities."

[26] Ramalingaswami V., U. Jonsson and J. Rohde (1996)
[27] Engle P.L and H.N.Ricciuti (1995)

Child care is seen as the responsibility of women, even more so in the city than in rural areas. All Tamang participants in a focus group discussion about family structures and gender roles[28] confirmed the statement of one participant: "Looking after children is our responsibility, bringing home enough money is the husband's responsibility." One participant cited another reason why the husband preferred his wife to stay at home: "They don't want us to work because we may go with another person." These statements frame the social situation in which women lead their lives: between chaste wife and responsible mother. According to a popular Nepali saying, "If the mother is good, the child is good." Women bear the main burden of raising children. Their well-being and attitude toward their daughters and sons thus have a significant impact on the child's nutritional status. We intend, first, to outline the key issues related to the role of women and by doing so to show how these affect the well-being of children.

In the second part of the chapter, we will discuss how the *generative themes* of water scarcity, poverty and underutilization of health systems affect the position of women and how they are affected by it.

In both parts of the chapter, we will focus on the interdependence of the *generative themes*, i.e., the broad social themes and the dynamics in individual families.

Readers not familiar with the cultural framework of Nepal may find this chapter a little harder to read. But it will become clear in what follows that it is not possible to understand malnutrition without being able to interpret the motivations of parents, and these are strongly influenced and guided by the values and attitudes of their particular cultural context.

[28] Focus Group Discussion (FGD) with 10 Tamang mothers in ward 35 of KMC, 12.6.2003

5.2 Position of women in family and community

Until a few years ago, Nepal was among the few countries in which women had a lower life expectancy than men. The structure responsible for this biological paradox is still largely in place although the most recent data show that women now live 0.4 year longer than men[29]. Women continue to have less access to education, health care, and to salaried employment. Women own assets (land, livestock, house) in only 17% of all households in Nepal [30].

The position of a woman in the family and community, however, varies according to the social group to which she belongs. The creation of "the Nepali woman" has been strongly criticized as the work of development agencies. "The patriarchically oppressed, uniformly disadvantaged and Hindu 'Nepali woman' as a category did not pre-date the development project. She had to be constructed by ignoring the heterogeneous forms of community, social relations and gendered realities of the various peoples inhabiting Nepal," according to social scientist Seira Tamang[31].

A very broad and general differentiation can be made between the two main categories under which the more than 50 groups and sub-groups in Nepal belong: Tibeto-Burman and Indo-Aryan. Women of the predominantly Buddhist Tibeto-Burman-liguistic groups live mostly in the hills and mountains. They travel widely on trade and business. They are respected for their involvement in income generation work and are comparatively freer in their social relations, for instance, in their choice of marriage partners. Women of the Indo-Aryan groups are subjected to much greater restrictions. Their honour is strictly guarded, first by their own family, and then by the family of their husbands. But even among the Indo-Aryan groups, the options and

[29] Central Bureau of Statistics (2003)
[30] ibid.

possibilities for women vary, depending on whether they belong to a Hindu high-caste or a lower caste, or whether the woman is a Brahmin of the Far-Western Region of Nepal or of an urban middle class family.

The limited opportunities for a woman, and the expectations that she herself and her community have of her, play a crucial role in the family dynamics. To understand those dynamics, we need to look at the prevalent family values, and at what is perceived as virtuous and normal, or bad and dysfunctional, by the wider community and by the group to which the family belongs. What incite tensions and causes disruption in a Hindu high-caste family may be a minor issue in a Tamang family.

Awareness of such differences is especially important in the context of the Urban Nutrition Project, where visitors are often not from the same social group as the family they visit. If they apply their own values to interpret the family visited, they can distort and misinterpret what is happening there.

Instead of presenting a general exposition on the position of women, we will present case studies to show how gender roles and personal dynamics are entwined and what major effect these have on the health of the child. While interpreting these examples, we will provide background in relation to the key issues defining the situation of women in the various communities of Kathmandu.

5.2.1 Sex and marriage

The reputation of a woman is of paramount importance to the honour of the Hindu family. Before marriage, this mainly means the protection of her

[31] Tamang (2002: 163-164)

virginity and after marriage her demonstrated deference to husband and in-laws is crucial. Women may move out of the family house to take up employment, but they will live with relatives who protect them. Women will first be guarded by their fathers or brothers, then by their husbands, and following them by their sons. In this scheme, marriage is of overwhelming importance and pre-marital sex is taboo in the matrix of values subscribed to and propagated by high-caste Hindus. It is generally believed that members of the Tibeto-Burman speaking groups are more liberal about this taboo. To understand the situation of a particular person, it is, however, as important to know her history and characteristics as it is to know her particular socio-cultural context, as the following case will show.

Mina Lama

Mina, the daughter of a high-caste woman and a Tamang man, left her family and village when she was 20 years old. She came to Kathmandu to work on a construction site. Unmarried, she lived by herself. As living alone as a single woman is uncommon, rumours soon circulated that men visited her quarters, to which she provided strong refutations. Once her friends locked her up with a man for a night. She knew the man and didn't like him. He was known as a drunkard and a womanizer. But after being forced to spend a night with him, she felt she had to marry him. She thought it would be too difficult to continue her unmarried live after "everybody knew that I spent one night with a driver." She continued staying with him against the advice of her brothers, who wanted her to abort the child and return home to the village. After moving in with her husband, he continued to "use all the money on girls." Although that changed after she delivered her daughter, she could never reconcile herself to the circumstances of her marriage. Ashamed, she led an isolated life. While her husband went away on work all day, she stayed within the confines of her rented quarters with her daughter and kept away from people.

When we met her daughter, she was 18 months old and malnourished. She had been suffering from constant diarrhea since she was 3 months old. She was very fussy about food and often rejected it when it was given to her by her mother. Mina felt increasingly helpless and frustrated with her attempts to help the child grow. The conclusion we reached was that while Mina tried to be a conscientious mother, she

> actually rejected her child as the symbol of her shame. The girl reacted very strongly with constant illness, among other symptoms

We will discuss this case in greater detail in the next chapter. Here, we briefly discuss the values that influenced Mina's difficult choice.

In a Hindu marriage, especially among high-caste families, the virgin daughter is given away to the groom. The arranged marriage is really a contract between two families rather than between two individuals. When a man and a woman get married without the mediation of relatives, they are said to have a "love marriage." Love marriages are more common in the Tamang community to which Mina Lama belongs. According to participants in the Tamang Focus Group Discussion about family structures, an arranged marriage is still preferred, but if "the boy is educated and has employment," the families will agree to the choice of the young people, even if the two belong to different castes. The behaviour of Mina's friends may have been an unconscious reference to the custom of "capture marriage" practiced by certain ethnic groups. "In a capture marriage, the bride is captured by the groom and his friends, and is whisked away into married live."[32]

It should be remembered that Mina's brothers did not agree to this marriage, mainly because Mina didn't choose her husband out of her free will and because of the man's bad reputation. The brothers would have accepted it if Mina had aborted her child, thus removing the evidence of her involvement with the man, and moved back to the family until a more agreeable match could be found. For Mina, however, this was no option. Her boundaries had been violated by the rape and she found it difficult to accept herself after that. Rape victims often feel such self-rejection, but additionally, they feel the

[32] Bista (1991:64)

brunt of the community's strong stance on "loose women," and they end up to marry the perpetrator in an attempt to save face. That may have been further reinforced by Mina's internalization of society's strict rules imposed on a decent high-caste Hindu woman, instilled in her by her high-caste mother.

After being forced into premarital sex, Mina saw only two options: marriage to her perpetrator or return to her maternal home. Either choice deprived her of the autonomy she had claimed and come to experience for herself.

5.2.2 The precarious position of the daughter-in-law

The authority structure in a Hindu family is clearly based on male superiority. A woman can gain power and respect by diplomacy and alliance. As long as the husband is still under the control of his parents, she must pay deference and respect to her in-laws. Any expression of open support she gets from her husband can be interpreted as a show of disrespect for his parents. Later, after the in-laws' death, she may acquire her status more directly through her relationship with her husband. Once her sons get married, they will bring home daughters-in-law, who will be at her command. She may derive considerable influence through her sons when they attain the status of senior males[33]. For a woman, the marriage of her son marks the culmination of a "long and difficult transition from a lowly incoming bride to a senior affinal woman. She who was beneath everyone will now recieve patrifocal deference from her new daughter-in-law. Moreover, her new daughter-in-law will be expected to do all the hardest work (…). She is thought of as her mother-in-law's servant," writes Bennett[34]. Although Bennett's remarks relate to Brahmin and Chettri families,

[33] Bennett (1976)
[34] Bennett (2002:180)

similar structures are common in the Newar community, as observed by Sagun staff in the wards and reported by Newar volunteers[35].

In our sample, the difficult position of the daughter-in-law had a direct or indirect influence on the status of the children's health in five cases. Two of them were Tamang. Although the Tamang FGD participants said the relationship between the mother-in-law and the daughter-in-law was less conflict-ridden in their community, these examples show that while general patterns can be discerned in a community, there is always the unexpected idiosyncracies of a particular family.

Sharmila Lama

When Sharmila Lama (23) was pregnant with her now 26-month-old daughter, she lived in the village with in-laws who treated her badly. Her husband worked in Kathmandu and was not able to protect her. The situation became worse after she delivered Sita, a daughter. Her mother-in-law had wanted a son. To punish Sharmila, it seemed, she didn't give her any strengthening food as is the custom following delivery. For one month, Sharmila could not produce any breastmilk. She was allowed to rest only for seven days, after which she had to return to regular field work, leaving the baby in the care of the mother-in-law. After a month, Sharmila's father came to take her home. During her stay there, she was given good food and care and was able to rest and stay with the baby. The breastmilk started coming, and she fed exclusively until the baby was 5 months old. She chose to stay in the maiti[36] for 10 months because she didn't want to face her mother-in-law. When she knew she could live in a separate house, she agreed to return with her husband, and they subsequently moved to Kathmandu.

Sunita Tamang

Sunita Tamang (24) lived with her in-laws in the village, while her husband lived in the city. She didn't get along with her mother-in-law, who made her work very hard. When she was 9 months pregnant, Sunita's husband brought her to Kathmandu, where he had found a well-paying job. In the hospital Sunita delivered a tiny (2kg) infant. As is the custom here, she thereafter immediately returned home. The

[35] Focus Group Discussion with Newar volunteers, 18.5.2003
[36] maiti/maita = maternal home of a married woman

husband had to go back to work after 3 days, leaving her to care for the baby and do all the work. She was completely exhausted and hardly left her bed. She didn't cook anything for herself; neither did anyone cook for her. The in-laws didn't support her because she had given birth to a girl. Sunita wasn't able to breastfeed. When the child was two months old, they moved to another room where neighbours helped her with cooking. After some time, the breastmilk started coming.

Not surprisingly, both mothers were able to produce breastmilk as soon as they received support. The key issues in Sunita's and Sharmila's story have to do with the emotional stress, hard work and insufficient diet they were inflicted with before and after delivery, and therefore, with the crucial issue of the daughter-in-law's position. The other significant issue in Sunita Tamang's experience is the isolation and lack of support she underwent as a new arrival in the city. That will be discussed in section 5.2.6.

5.2.3 Son preference

An important thread in the two stories above is the matter of discrimination against girl children. The parents-in-law of three mothers in our sample reacted negatively to her because she had delivered a girl.

The neglect of the child by her own parents because she was a daughter was identified as significant in the following case of malnutrition:

Sita Thapa

Sita (25) had been brought for weighing from the time she was two months old. Her weight started to deteriorate from the fourth month and subsequently fell below 80% of the standard weight per age. She grew along the lower marker line of the "Road to health"-card up to eight months and then deteriorated further. A volunteer was assigned to the case. This is what she found:

The family had two daughters; the elder was 3 years old, the younger, Sita, was 9 months old. The father had a garment business, which indicated that their economic situation was reasonable. They lived in two rooms and the volunteer approved of their level of cleanliness.

When the mother was pregnant with her second child, a relative predicted that the baby would be a daughter. Since the family already had a daughter, they very much wanted a son and the prediction caused the mother a great deal of tension. When she delivered the girl in the maternity, Sita weighed only 2.1 kg. For the first few months, however, the girl's weight developed well within the markers of the "Road to Health"-card. When she was 4 months old, her mother's father got very sick and her mother had to attend to him. On her frequent visits to his house, she took the older girl along and left Sita alone in the room. As the mother was not home much, she stopped exclusive breastfeeding and introduced Cerelac. The baby cried a lot, often had diarrhea and also vomited. When she was 5 months old, the mother's father died. The mother began to spend more time at home, but the child did not recover.

The volunteer observed that the older daughter looked like a boy and the younger daughter didn't have the customary holes in her ears for earrings. She asked the mother whether that was because she would have preferred a son. The mother acknowledged that she would have liked a son. When the volunteer suggested that the mother cook jawlo[37] for the younger daughter, she said she did not want to cook an extra meal for this child, and that, moreover, the older daughter didn't like jawlo. The mother continued to take the older daughter with her when she went out, leaving the small child alone at home to cry for long periods of time. The volunteer also observed that the mother immediately put down the baby from her lap when the older child approached. The mother said that the older child was unproblematic and that she had never had any difficulties with her. In contrast, she complained about the younger daughter, saying she refused food and was difficult. Both parents expressed their frustration with the child. They didn't appear to make an effort to follow the volunteer's suggestion to feed her frequently and to patiently support the child's eating.

The key issue in this story would appear to be the mother's ambivalence toward her second girl-child. It began during her pregnancy and may have

contributed to the girl's low birth-weight. It is known that the emotional situation of a mother during her pregnancy affects the unborn child. During the mother's father's sickness, this ambivalence turned into outright neglect, which can be seen as an expression of her difficulties in coping with the demands put on her. The child's reaction to that may have in turn further aggravated her attitude, thus causing the cycle of disappointment, frustration, and further neglect.

In the Hindu high-caste matrix of beliefs, a son's birth is considered to be auspicious, while the birth of a daughter is marked by sadness and fear – "sadness because a son was not born and fear because she is a potential threat to the honour of her father's patriline."[38] Sons are favoured because they represent the collective. In Hindu belief, they have to perform the death rites for the parents. Only if a son lights the funeral pyre is there a chance for the departed soul to reach heaven. A son also takes care of the parents when they are old, whereas a daughter is destined to leave her family and become part of another patriline. According to a Nepali saying, bringing up a daughter is like watering the neighbour's plants.

When we discussed the matter of son preference with the volunteers participating in this study, it was striking with what intensity they had hoped each time the child would be a son and, correspondingly, the family tensions caused by a daughter's birth. One volunteer said that after having two daughters, she did not want to deliver her third child in hospital "because they exchange children there." She delivered at home and when her husband said the baby emerging was a boy, "that gave me so much strength and energy to carry on." All the others confirmed her experience and one said:"We should

[37] Jawlo = a traditional mix for babies made of rice, lentils and vegetables
[38] Bennett (2002)

have at least one son. Boys light the fire on the dead bodies and carry on the family name." One of the volunteers expressed her disappointment that her arrival in the world was regretted by her family. "I get very angry when I think about it and to know that my own family was like that," she said. One participant said that her husband had spoken against the discrimination of girls and had told his mother that his daughter would light the fire on the pyre and that would be acceptable. Another participant said that the clinic staff had advised her not to renew her Depo Provera and instead to have another child as she only had a daughter. She had replied:"It's selfish to have children only so they can serve us later." It was striking to note in these small examples how much energy and resistance was generated among participants when they confronted the issue.

The visitors were very conscious of the implications of son preference in the upbringing of girls and were looking out for such signs. The evidence was clear only in Sita Thapa's case. However, it has to be said that, at times, the discrimination of a child is neither conscious nor openly visible. We can assume that son preference would influence, to some degree, all families that have only daughters. Given society's preference for boys, we can assume that the status a woman gains or loses, depending on the sex of the child born, will influence her self-esteem. Further, it will shape her attitude toward daughters and may always be one of the subliminal factors leading to malnutrition of girls.

5.2.4 Maiti: The ambivalence in a woman's relation to her maternal home

At marriage, a woman leaves her maternal home or maita and has no more rights there. According to the new inheritance law, a woman loses the right to

property from her family of origin once she gets married. Despite that, her maita remains an important place for her. During her visits, she is well cared for, given good food, and made to do only the lightest of chores. Generally, women go to their maita after delivery to recover. They can, however, make this visit only after the "name-giving ceremony" that establishes the child's patriline. Once the child has a name, the mother can stay with her maiti as long as both families allow it. Our informants talked of periods of stay lasting between one and several months. If a woman finds it difficult to live with her in-laws, she may consider staying on in her maiti. According to Newar informants, that would amount to an informal divorce. It is, needless to say, strongly disapproved off by the community. The Tamang women with whom we discussed this issue confirmed that all parties involved would avoid such an arrangement where possible. One of them explained:"If the woman is intelligent, she will not stay at the maiti. There is nothing for her there. Ultimately, she must return to her husband's house. Her children belong there and her property is there. In the maiti, she has nothing."

In two cases, we found that the relationship of the mother to the maita influenced the family dynamics and probably the well-being of the child. Here, we will allude to one story to illustrate the difficulty of a woman's choosing to return to the maternal home as a coping strategy.

Anita Shahi

Anita Shahi, a young Newar woman, found life very difficult in the joint family of her husband and decided not to return there after she delivered Parvati. Instead, she went directly from the hospital to her maita even before the name-giving ceremony for her daughter. She stayed on in her maternal home and her husband later joined her. This arrangement was seen as unacceptable by Sagun's Newar volunteers and it was difficult for all the family members involved. Anita spoke of how she felt the situation affected the child: "Parvati likes her father but he doesn't play with her, and he comes home late. I think my

> husband goes to his family home during the day." She seemed to be very bothered by his attachment to his family and his divided loyalties. Although she was well looked after in her maita, Anita did not feel comfortable with her choice. She hardly left the house and rarely mixed with other people, perhaps because she feared the judgment of the community. Husband and wife had frequent arguments, according to Anita, because he "listens to his mother too much." After such arguments and fights between her parents, the little girl was unable to sleep. She also often chose not to eat when the atmosphere was tense between her parents. Their inability to find an individually and culturally acceptable form toward establishing the family unit thus had an immediate impact on the nutrition status of the child.

This story points to the great emotional stress that usually accompanies the break-up of a joint family. A young wife is often seen as a potential danger to the solidarity of her husband's group. In such a set-up, she can realize her interests only if she gains his support and thus wins him away from his loyalties to parents and brothers. "Often, of course, these lineal ties are already frayed by her husband's restlessness under parental control and the strong sense of competition between brothers. However, since agnatic rivalry is contrary to the dominant patrifocal ideology, affinal women … are usually the focus of blame for the constant household quarrels and, ultimately, for the inevitable segmentation of the joint family," writes Bennett about Hindu high-caste families.[39] Newar informants agreed that life in such joint families can be extremely difficult for the wife, one reason being the rivalry between brothers. Their parents and, especially the mother-in-law, would treat the daughters-in-law in relation to her preferences for the respective sons.

In the city, the extended family is not the norm. Many residents have migrated from the rural areas and set up nuclear families, sometimes including the husband's parents though mostly without other family members. Many Newar, who are the original inhabitants of the Kathmandu Valley, however, continue

[39] Bennett (2002:219)

to live in joint families. This family formation, including parents and their sons with their wives and children, is important in keeping the family business intact. But modernization and job opportunities outside the circle of relatives have made the joint family economically less necessary and its inherent instability generally leads to a break-up faster[40]. Although nuclear families are now more common in Kathmandu's Newar community, all three underweight Newar children in our sample lived in a joint family.

5.2.5 Second wife and violence in the family

Two families we met for this study were in a state of marked dysfunction and at the brink of falling apart. There were many entwining issues, but in both families, poverty, violence, alcoholism and the husband's pursuit of other women were key issues. The following story illustrates how these issues play upon each other and how they influence the well-being of the child.

> **Kumari Shrestha and her family**
>
> Kumari (16 months), an underweight child, was breastfed until she was two months old. That was as long as her father supported her mother Pabitri (32) without resorting to violent behavior when he was angry. When Kumari was 2 months old, he went back to his old ways, restarted drinking, and came back to beat her mother so badly that she could hardly move afterwards.
>
> Kumari's father, Vishnu, was a dada, a local strongman, who was feared in the neighbourhood. He didn't bring home much money. Pabitri's meagre earnings from knitting sweaters were spent on herself and her three daughters, but she was forced to hand money over when her husband demanded it. She and the children were supported financially by her husband's father who earned a decent salary as a mason. He and his wife lived with Kumari's family in the same household.

[40] Newar FGD participants

Thus, Pabitri's father-in-law seemed to hold the family together. He supported Pabitri financially, defended her against his son, and seemed generally to treat her well. It was rumoured in the community that Pabitri's husband, Vishnu, was enraged at his father, accusing him of fathering Pabitri's oldest daughter. But Vishnu directed his anger and his acts of violence at his wife rather than at his father.

The 12-year old girl was the favourite of the old man. She was given special attention and slept in his bed. It should be said here that children often sleep with their parents, but it was unusual for a girl her age to do so. Vishnu, Pabitri's husband, finally left the home and moved in with a second wife.

The volunteer who visited this family soon realized that it was useless to tell Pabitri about good care practices. The family was in such a state of dysfunction that learning about feeding frequency was not a priority for the mother. This was the only case in the study in which the visitor gave up on the family. She couldn't handle the complications and was frightened by all the violations in this household.

Maiti Lama and her family

Maiti Lama's family was also disintegrating in front of our eyes. The mother seemed at times to be fuzzy as to how many children she had or where they were as she had moved from one husband to the next, each time abandoning her children. Presently, she lived with her husband and their two sons. Her husband was a womanizer and, inevitably, disappeared with another woman. The mother slipped into a deep depression and was hardly able to move about or to look after her children. She subsequently left for the village with her two boys.

We were actually surprised to encounter this level of dysfunctionality in only two families (alcoholic father in three cases) as alcoholism and domestic violence are highly prevalent, according to volunteers of the project area. The problem of the second wife was also a recurring thread.

Women and children often have nowhere to turn to for help. Even when women earn the principal part of the family income, they hesitate to move out or to seek separation or divorce. Until 2001, the law allowed women to claim food from the husband for five years after the divorce. Now, they have the right to claim property. Living separately, though, is still quite an unusual arrangement for a Nepali woman.

Women without husbands, or divorcees and widows, are looked at with suspicion by society. Social scientist Dor Bahadur Bista claims that orthodox Hindus consider it "unlucky and inauspicious to see the face of a woman who is either widowed, without a male issue, or a spinster"[41]. Widow remarriage among orthodox Hindus is very rare. Recently, the wedding of a young high-caste man to a widow of 17 years was celebrated by the main Nepali English daily as an act of exemplary courage by the groom[42]. In our study, one mother was a widow. She lost her husband when the child was 45 days old and consequently had to deal with a traumatic fall in social and economic position. The child's health was severely affected by that.

Women not under the control of a husband have to prove, more than other women, that they follow the moral path of maintaining their chastity. Often, they have to fight suspicions cast upon them that they are of loose morals and sexually available. The question as to who in the family will support these women comes up, and it is an economic issue too. In this context, a woman will not take lightly a decision to move away from an abusing husband. We came across very few female-headed households in the project area.

[41] Bista (1991)
[42] Chapagain (2003)

5.2.6 Lack of community support systems for women

A recurring key issue in many of the families visited was the isolation of the mothers. They often didn't have a support network, either as a result of their personal history and feelings of shame, as in the case of Mina Lama and Anita Shahi, or because they had newly moved to Kathmandu and were without relatives or friends.

Women's isolation in Kathmandu is also caused by their role as primary caregivers of children. Their duties keep women within the confines of their own household, their relatives or the small community of renters in their own courtyard. This kind of isolation was felt very strongly by many volunteers who have been living in the city for a long time. When the participants of the Newar Focus Group Discussion were asked what they would change if they could, the majority said they would make it possible for all women to get a (paid) occupation outside the family as that would improve their status at home and provide them an exposure that would allow them to learn and grow. Indeed, the volunteers are examples of women that have taken this step; most of them were enthusiastic and appreciated the impact it had on their situation at home.

Also, in many of the families we visited for this study, we observed the impact of the visitor on the family in breaking through the mother's isolation. The encounter with the volunteer opened up an emotional space, helping them to talk about and reflect on their situation. Home visits, as a first step of connecting women to the outside world, supported by opportunities for women to meet and network, is thus a vital component of a project that seeks to improve the nutritional status of children in Kathmandu.

Besides, there are no opportunities for families to gain support in their care for children. Child care centres hardly exist and are expensive. Families thus send their children to private schools as soon as possible, often already at the age of three. No facilities offer care for children younger than three. With the establishment of small community-managed child care centres, Sagun is thus filling a big gap. Family members are reassured that their children are well taken care off while they are at work. Also, parents are involved in the organization of the crèches and that provides an opportunity for networking among families, especially among mothers.

5.3 Inadequate household food security: Poverty in the capital

Kathmandu is considered well-off and developed, compared to the rest of the country, and thus not worthy of receiving development projects. But the capital's population grew by 60% in the last 10 years and it also has the widest income disparity in the country. While the per capita income per year of Kathmanduites is US$ 2,091[43], about 70% of the city's population are estimated to be poor[44]. The once thriving tourist industry is a pale picture of what it used to be - as a result of the escalation in 2001 of the armed conflict between the army and the Maoists. The garment industry, too, was adversely affected by political instability. The carpet industry, which was formerly the primary foreign exchange earner, was hard hit in the late nineties because tastes changed in the international carpet market. A huge sector of the population thus finds itself unemployed, under-employed or self-employed. With distinctly limited possibilities for work at home, droves of young people,

[43] www.asiaweek.com/asiaweek/features/asiacities2000/23kathmandu.html
[44] Lumanti (2001)

overwhelmingly men, leave Nepal to seek employment in India, the Gulf or South-East Asia.

The poor in Kathmandu live in overcrowded dark, damp rooms, with many families living in one building. Sometimes up to 20 or 30 families share one toilet and one water tap. To get a better picture of the living conditions of urban lower middle class and poor, we asked 76 volunteers from two wards of the Urban Nutrition Project how they live and work. The volunteers live in the communities where the Sagun project is. Their living conditions are comparable and thus provide a picture of the context.

Three quarters of the volunteers are renters, one quarter are house owners. Most respondents said that they lived with their family in one room (47%), and an additional 21% lived in two rooms. The average rent for one room in the old city was found to be Rs. 800 (US$ 10) and Rs. 1,260 (US$ 16) in a ward on the outskirts of the city. More than half of those that lived with their family in one room earned Rs. 3,500 (US$ 44) or less per month.

Of the volunteers, 40% stayed at home and worked in the household. An additional 29% worked mostly in the household but had some irregular income work at home such as making bead necklaces, preparing superflour, or sewing. One third of the volunteers worked outside their house, regularly or irregularly, for income; most of them worked in garments as daily labourers or in their own shop.

The families in our sample were poorer than the volunteers (Table below). The 14% that earned more than Rs. 5,000 (US$ 63) per month were, by Kathmandu standards, financially relatively stable. Half of the families earned between Rs. 3,600 and Rs. 5,000. Their situation became precarious if and when

Table 5: Income distribution among families of volunteers and families of malnourished children in the sample for this study

Income per month	**% of volunteers** N = 76	**% of families of malnourished children** N = 22
Up to Rs. 3,500 (US$ 46)	30	36
Rs. 3,600 – 5,000 (US$ 45-63)	29	50
Rs. 5,100 – 9,000 (US$ 64 – 123)	29	9
Rs. 10,000 and above (US $ 125)	12	5

Source: Sagun

unexpected expenditures occurred (e.g., medical treatment over a longer period of time, increase in rent, etc.). Families with income less than Rs. 3,600 per month, however, were struggling. Out of 22 families visited, 8 were in this situation.

Poverty is caused by exploitative conditions in the labour market and in the informal sector for the self-employed. The particular form poverty takes in each individual case, however, is influenced by the personalities involved. The stress and insecurities resulting from a constant shortage of income, or from debt and crowded living conditions, can trigger psychological problems in people who are otherwise healthy. On the other hand, people who suffer from psychosocial impediments are often those unable in developing strategies to cope with poverty[45] .

In our observation, there was a close link between the effects of financial insecurity and the social conditions and personal histories of the family members.

In each of the eight families earning less than Rs. 3,600 monthly, a lack of resources and the psychosocial misery played on each other and made it

[45] Rauchfleisch (1996)

difficult for the parents to provide the food, the emotional security and the care required for children to thrive. One example was Raji Rai, who seemed to be suffering from depression.

Bimla and Raji Rai

Raji Rai (26) lived with her daughter Bimla (11 months) and her husband in a small room in the old section of Kathmandu. The girl's refusal to eat was diagnosed by the doctor as anorexia. Bimla often suffered from diarrhea too.
The child sat on the mother's lap most of the time, disinterested in playing. Raji cooked in the morning and fed the girl cold left-over food twice during the day. She said that since the child didn't eat, she didn't feel like cooking. She never tried the easy-to-prepare superflour the volunteer had brought her as an additional nutritious food. In the volunteer's observation, the mother was passive and listless.

The family was poor. The husband, who generally painted houses, was without work and sold peanuts on the streets. Raji remarked: "We are poor, we are the poorest here. Nobody should be poor like us." The volunteer came to see that Raji didn't heat the food because she couldn't afford kerosene. She didn't boil the water for the same reason. The volunteer did not understand though why Raji's room was so messy and dirty. When asked why she didn't clean, Raji said she had to fetch water from the water tap at 2 am. This reason didn't impress the volunteer as she and many women in the neighbourhood had to do the same (see 5.4).

Raji's sister-in-law lived in the same building and was sometimes present during the volunteer's visit. Together, they discussed ways of feeding the child and Raji's desperate economic situation. The sister-in-law was illiterate too but very energetic. She earned her income as a vegetable vendor. A few weeks after the home visits started, she took Raji along and showed her how to sell lemons on the street. This initially boosted Raji, but not long after, she gave it up. She had not done her calculations properly and gone into loss.

The economic situation of Raji's family was severe and key in the child's nutritional status. The poverty of the family and Raji's passivity were closely linked, each affecting and reinforcing the other.

In four of the seven very poor families, the visitors saw ways in which the mothers could improve their financial situation. But all of them, each for individual reasons, were unable or disinterested in trying out the suggestions. As the case of Sushila Moktan illustrates, this could have meant that the personal history and emotional situation had not been understood or addressed by those wanting to help the families to improve their economic situation.

Sushila and Shanti Moktan

The visitor found the only female-headed household of our sample in a small room on the ground floor of an old building. Suhsila (24) told the visitor that her daughter Shanti (31 months) had been very big at birth, and she had needed a caesarian. But when Shanti was 45 days old, her father had been run over by a truck and died. Sushila believed the truck driver might have done it intentionally as her husband had argued with him the day before. She had fallen unconscious for the entire night after the event. While she organized the cremation and fought for compensation, the landlady had taken care of the baby, feeding her cow's milk. Left without any income, Sushila became a vegetable vendor. These family dynamics and individual characteristics in turn mediate how resource constraints are handled and affect the nutritional status of the child. The material we When her husband was alive, he had earned Rs. 7,000 to 9,000 as a construction overseer. Now Sushila earned Rs. 1,500 per month, far too little to live in Kathmandu. Not only were her earnings so meagre, but sitting on the pavement also exposed her to harassment by men. Her situation made her so angry that, sometimes, she hit her child when she returned home. Besides, she had to leave the child alone for long stretches of time when she went to the wholesale market to get the vegetables. In a 24-hour-recall, the visitor found that the child was not fed enough.

The mother talked about her desperate economic situation and described how the police daily chased the vendors away from their selling point next to a UNESCO heritage site. The municipality disallowed any selling there; the police seized the vegetables and the weighing scales if the vendors couldn't run away fast enough. Sushila talked about these encounters in great detail and with great emotion. The visitor wanted to know whether Sushila had thought of other livelihood options. Sushila said she thought of opening a tailor shop and wanted to undergo some training. Hopeful, the visitor made an effort to find out about training possibilities. When she presented her suggestions, Sushila seemed disinterested. The visitor then hit upon the

idea of the vendors organizing to demand better conditions from the municipality. Sushila agreed initially, but later, found reasons why it was not possible. A few weeks later, the visitor made another attempt to offer Sushila a training opportunity for tailoring, but again the mother found reasons to turn it down.

Finally, towards the end of the visiting period, Sushila found a way of organizing a vending space in a more protected area where she did not have to run away from the police. Although she didn't really earn much more and certainly didn't move up as much as she would have with her own tailor shop, she took a small step to improve her working conditions and one that allowed her to remain in the vendor community among whom she had found friends.

The mother's downfall, from being a financially secure and socially well-regarded housewife to a street vendor, is of central significance in this story. The mother had talked about it only in the first two visits and then shifted her narrative to the fights between the vendors and the police and to her low and fluctuating daily income. She described these incidents with great intensity and over many visits. What she in fact talked about was her frustration and anger about having to be a widow, a single mother and a vendor. Although she may have mentioned her wish to move up socially by having her own tailor shop, her economic situation was too precarious for her to dare experiments. She was also probably too scared of failing in her attempt to improve her social status and couldn't face the prospect of being humiliated from yet another downfall. With the change she finally made, she improved her situation just so slightly that she could feel a little more comfortable. This was, at that time, her only possible option, though it may not have brought her a substantial increase in income. Steps to make real changes cannot usually be made from an insecure and precarious base.

While it may seem beyond the scope of a nutrition project to consider income generation, we believe there are possibilities of linking poor families with

existing opportunities in their neigbourhoods for income purposes. But as the experience of Sushila Moktan illustrates, such initiatives would have to go hand in hand with building the understanding of staff and volunteers that poverty and possible coping strategies must always connect to the very specific situation and experience of the poor family. Just presenting people with opportunities that happen to be available will rarely solve the problem.

5.4 Water Scarcity in Kathmandu[46]

In the earlier example of Raji' who was too depressed to care adequately for her child or to contribute to the family income (see 5.3), as additional difficulty, water scarcity affected her ability to keep her house clean. The volunteer dismissed it as another expression of Raji's passivity because she herself had to queue up at night to get water for her household.

Access to water is an enormous problem in Kathmandu. It results from the inadequate supply of water to the Kathmandu valley and poor water management. During the dry season, from November to June, Kathmandu gets only about half the water resources the city's residents require. And 35% of these resources are lost to leakages[47].

[46] This section is based on verbal communications with Alan Etherington, Director of WaterAid, Nepal

[47] The problem could be reduced substantially by repair and proper maintenance of the distribution system. In the World Bank's estimate, an input of US$ 5 million would reduce the leakage from 35% to 28% and it could be done by sending crews of semi- and unskilled personnel to mend the connections of the supply lines. However, a reluctance to implement such measures is one of the many symptoms of the very poor functioning of the water management body, the Nepal Water Supply Corporation NWSC. The NWSC prefers big investments in equipment that bring high returns in the form of commissions rather than small and work-intensive repair initiatives without much expenditure on hardware.

Another problem of city residents is the arbitrary distribution of these limited water resources. Those that get their water from a main line have access to water for six hours every day while others get water for half an hour every alternative day, with this short period sometimes falling in the middle of the night. Consequently, women of households without a private connection have to spend many hours at night in queues in front of common water taps to fetch water. During the short supply periods, those that can afford it take out as much water as they can resorting to electric pumps, while poorer neighbours without such pumps have to be contended with the remains. In neighbourhoods of the old city in particular, people have access to additional water from the traditional stone-water sprouts, though the water is of poor quality This contributes further to the high prevalence of water-borne diseases since most people don't boil their drinking water (see 4.2.4).

The water is distributed by personnel of the Nepal Water Supply Corporation who walk around with a stick to open and close the vales. This system, arbitrary and vulnerable to corruption, is a cause of considerable conflict in the communities.

In many of our case studies, mothers complained about the lack of water in their neighbourhood. Often, the visitors did not adequately recognize nor acknowledge water scarcity as a key issue for hygiene. They were more likely to blame mothers of being lazy in cleaning up. We didn't quite understand this until, one day, the water issue came up in a meeting with volunteers. They complained that they had spent yet another night waiting for the water to come and that another part of their ward got all the water while they got very little. They blamed the valve-man for favouring "those Maharjans," members of another caste that lived in the area. The emotional intensity of the discussion

made us realize our casual disregard for mothers' complaints about water problems.

In Nepali society, dirty habits are generally associated with poverty, ignorance and carelessness and, thus, shame[48]. Cleanliness is the responsibility of women as is the fetching of water. Both visitors and the mothers had to cope with the same conditions. Both of them had no control over the timing and amount of water delivered by the water supply system. Instead of acknowledging such powerlessness as a starting point for a reflection on possible collective action, it seemed a more familiar course of action to assign blame to individuals who were less able to cope.

Water scarcity is an issue Sagun wants to take up in future. An enormous amount of energy will have to be invested in motivating women for collective action. Social activism is very young in Nepal[49] and women in the project area have never organized themselves to address a common cause. The little experience that some have was frustrating as all their efforts were blocked by inflexible and unwilling bureaucrats and politicians.

5.5 Underutilization of bio-medical facilities

The Urban Nutrition Project of Sagun and *Terre des hommes* is the first community- based nutrition project in Kathmandu. One reason why nutrition work is considered less needed in the capital by many development agencies is the density of health services not reached anywhere else in the country. The Kathmandu Metropolitan City has a network of 18 ward clinics, small facilities that are geared toward providing well-baby clinics and very basic primary

[48] Kristvik (2001)
[49] Thapa (2003)

health care in the 35 wards of Kathmandu. The National Children's Hospital, the Maternity Hospital and two other big government hospitals, as well as numerous private hospitals and clinics are situated in Kathmandu. And yet, in talking to volunteers and families, we found that many use these facilities only in circumstances that are exceptional and often as a last recourse. This hesitation has two main reasons: 1) The attitude of people to the bio-medical model and 2) the unsatisfactory experiences many people had in their dealings with hospital and clinic staff. Interestingly, the fees for the services at government facilities were never mentioned as a deterrent.

The bio-medical model is only one among the many different medical systems and beliefs practiced in Kathmandu. Anthropologist David Gellner lists non-biomedical healing practitioners available in the Kathmandu Valley: Hospitals and medical shops providing cure on the basis of Ayurveda, the classical South Asian medicine based on Sanskrit texts; Hindu and Buddhist priests and monks and individuals carrying out healing rituals; astrologers; tantric healers, shamans and mediums dispensing divine healing, and midwives or other individuals offering herbal remedies. We should add the growing number of practitioners of Tibetan Medicine and Chinese acupuncture. As Gellner points out, the response to illness is eclectic, with most people using a mix of these systems. This attitude to healing is based on the assumptions of folk medical knowledge: "(1) there are many kinds of diseases; (2) different kinds of diseases have different causes and require different treatments and different practitioners; (3) all diseases are curable if the appropriate practitioner can be found; and (4) appropriate practitioners are best identified through personal contacts and particularly through the advice and counsel of friends and relatives."[50]

[50] Gellner (2001)

The most common approach to healing we found among Sagun's volunteers and the families of malnourished children in our sample is a combination of the cures provided by tantric healers, shamans and mediums together with the purchase of drugs at medical shops. Drugs are bought only exceptionally after consulting the shop's visiting doctor, mostly customers rely on the advice of the almost untrained salesperson in the shop. In addition to the purchase of often inappropriate drugs, people also have great difficulties to understand the instructions on how to take the medicine correctly. When the children of the study sample came for medical screening to Sagun, we observed how extremely difficult it was for caregivers to comprehend and remember the explanations on how to take medicine. If this is any indication, it is our guess that many caregivers do not administer the drugs correctly. We were sensitized to this malpractice when, in the first meeting with one mother (Mina Lama, chapter 6), the visitor discerned that she stopped giving the antibiotics as soon as she thought the child looked better. It was an important moment for the mother when she many meetings later finally realized that not giving the medicine correctly may have contributed to the recurring diarrhea of her daughter. - It would be useful to find out how much damage to children's digestive system is caused by the constant consumption of incomplete courses of antibiotics.

There is significant reluctance among many to seek treatment in clinics and hospitals, for one because of their interpretation of illness and the related possibilities for cure. Staff and volunteers of the Urban Nutrition Project do not discourage people from resorting to means other than bio-medical facilities. When Sagun volunteers encounter a practice that they deem harmful, they attempt to explain their view to mothers. Generally, though, they try to encourage some way of supplementing peoples' consultation of healers with a

consultation at a clinic or hospital. As mentioned, for many caregivers, this does not pose a problem as a matter of principle. What deters them from using hospitals and clinics more frequently is directly related to their experience of the authoritarian attitude of staff, and the disregard of people they often demonstrate. In addition, the services are unable to cope with the great number of patients seeking treatment. This leads to long waiting with what patients understand for little visible results. During training sessions, the volunteers explained why they hesitate to use the hospitals and clinics:

> When I wanted to give my daughter some food during her labour pain, the nurses scolded me:"Who will clean up when she vomits during delivery?"
>
> When I was in Thapatli hospital for the delivery of my son, the nurses there treated me very badly. When I was in labour pain, one of them said "you have such a big body and can't even deliver a baby". If I think of those moments, I hate going to hospital.
>
> When I was in hospital for my delivery, a woman nearby had very severe labour pain and cried. The nurse came and scolded her, using harsh words:"You didn't cry when you slept with your husband because you enjoyed it. Now when you are delivering the baby, you cry." Hearing her talk like that, I felt terrible.
>
> When my daughter had an ear problem I was sent from the Children's Hospital to the Teaching Hospital. There, it was very difficult for me to find the right consultation room but finally, I managed. After having waited for a long time it was my turn to enter the room. I showed the referral slip and tried to explain the problem. Without even listening properly, the doctor said "come tomorrow!" and closed the door. With a heavy heart I left and went to buy medicine at the medical shop.

The result of such experience is an underutilization of bio-medical facilities that may also be interpreted as resistance: "The patient-doctor relationship can become such an unequal engagement that poor patients find noncompliance

one of their only ways of resisting paternalistic authority and asserting what little personal efficacy they believe to be available to them."[51]

The reluctance to use bio-medical services was also reflected in our case studies. Whether or not women should go for check-up or caregivers should bring children to the clinic or hospital was often subject to long discussions between families and visitors. In six of the 22 cases, the visit to a doctor or clinic turned into a major theme in the interaction with visitors. A lack of trust in bio-medical services was expressed in all of these cases for different reasons. The case of Dina Ghimire illustrates that reluctance to use medical facilities may also be rooted in the individual history.

Dina Ghimire

Dina grew up in a family in a rural area. Her mother gave birth 15 times, but only Dina and six siblings lived to reach adulthood. After her marriage, Dina lost her first child in a miscarriage when she was 8 months pregnant due to hard work. When the visitor met her, Dina had been in Kathmandu for 6 years and had 3 sons. The first boy was 9 years old, the second was 3, and the youngest 18 months. The youngest, Kusum, was malnourished.

Dina had extremely difficult deliveries, especially with her oldest and youngest sons. She was in labour for 5 days while delivering Kusum. "He was very small, like a dwarf, when he was born", she said of her youngest son. When he was one year old, he became very sick and had to be admitted to the hospital for three days. "The doctors did nothing except give Jeevan Jal" (oral rehydration solution). At 18 months, Kusum was still sick all the time, with diarrhea and fever, and he didn't want to eat. The child ate normally for about a week, then had a bout of diarrhea or fever and had no appetite. The mother began taking the child to the shaman, after which, usually, he improved for a few days. The oldest son had to be brought to the shaman regularly too, with all sorts of aches and pains, body stiffness, headaches, especially when he had to go to school. Dina's accounts of the healers to whom she had gone to for different symptoms were significant in her meetings with the visitor. She also frequently talked about the death of relatives.

[51] Kleinman in Kristvik (2001:133)

The visitor found herself getting irritated with Dina's excuses for not bringing the child for medical check-up. Finally, after much discussion, she very reluctantly came to the clinic with the visitor. She however forgot to bring money and was not able to buy the prescribed medicine. Another time, she accompanied the visitor to the Children's Hospital, where they gave out worm medicine but didn't carry out any tests. She was even more certain hospitals were useless, as she could have got the medicine from a store and saved herself a trip. When she came to Sagun for medical screening, the child's stool did not show up anything. But after the screening, the child had fever again, and she thought there was a connection. All the contacts with bio-medical facilities seemed to reconfirm to her that her children could not be helped.

The visitor finally understood that Dina only went to healers who were connected to her village and she went to the medical store because someone from her village worked there. She checked with him the cough medicine she was given at the screening in Sagun. She found it difficult to trust anybody outside her own social network. Understanding this, the visitor's sympathy for Dina grew. And the mother responded by talking to her more personally. At the last growth monitoring session for this study, the child's weight showed improvement for the first time.

Unfortunately, within the framework for this study, there was not enough time to understand why she had such difficulties in trusting outsiders and also to understand what we suspected were psycho-somatic symptoms in her two sons. There is reason to believe though that her attitude to sickness and to her children came from her experience that children more often than not did not survive. She needed to control her anxieties by consulting shamans she trusted, in the search for treatment methods that had been applied to her and her siblings – sometimes successfully and in eight instances to no avail. A hypothesis might be formed that this mother had dealt a lot with death and did not in her heart believe children could survive, and thus, unconsciously, may have created a situation to, indeed, make it difficult for her sons to thrive.

Dina´s attitude to bio-medical services and to health care for her children in general was coined by her individual experience. This was true for all other caregivers who were reluctant to visit a clinic or hospital: One mother, despite

repeatedly saying she would go for a check-up for her own health, found reasons not to do so. Neither did she bring her child to Sagun for the medical screening. She seemed to be in a state of depression and couldn't take action. Another mother, Maiti Lama (see 5.2.4) was coughing blood and was suspected of having contracted TB. She, too, vowed to go to the clinic but never showed up. She was preoccupied with her dysfunctional family that was about to fall apart and the extreme poverty in which she lived. In addition, people consider TB a shameful disease, linked to poverty and "dirty habits". Another mother gave her reason for not going for pre-natal check-up to her distrust of the capacity of the doctors at the hospital. We wondered, however, whether her reluctance to go wasn't an expression of her ambivalence toward her pregnancy, which she had kept a secret for seven months (see Anita Shahi, 5.2.3 and chapter 6). Finally, one mother refused to go for ante-natal check-up because of the shame she felt in being physically checked by a stranger.

Access to health care covers three main facets a) economic access, b) geographical access and c) cultural access[52]. *Geographic* and *economic access* are basically unproblematic in Kathmandu. However, people sometimes do not consult the hospitals because they would have to travel across town and loose a lot of time waiting for their turn which is especially problematic for daily labourers. Most of the reasons the caregivers give for not consulting hospitals or clinics could be summarized under *cultural access*: People judge traditional and folk medicine to be more effective than bio-medical treatment for certain conditions. And, the attitude and communication behaviour of service providers often act as a deterrent for people to access health services. In addition to these common themes each family has it's individual reasons for a

[52] Hutton, 2002, Equity and Access in the Health Sector of Eastern Europe and Central Asia: A brief review of literature, SDC and Swiss Tropical Institute, Bern and SDC-Health: Access to health services, www.sdc-health.ch/priorities_in_health/

decision of whether or not a medical facility will be used. Much thus depends on the psychosocial dynamics of the patients.

Sagun works on an improved access to health care on several levels:

- individual: working with caregivers to increase their preparedness to go to the clinic;
- community: increasing the understanding of the need for certain medical services and thus increasing the pressure on health facilities to deliver quality care;
- ward clinics: working on improving the capacity of the municipality's ward clinics. These clinics are managed by a committee of citizens and staffed with two health workers and a helper each. Much depends on their attitude to clients and their ability to communicate with them.

5.6. Conclusions

Care practices for children are influenced by **generative themes**, i.e. social and political issues relevant in a certain context. In Kathmandu, these generative themes are: "Position of women in family and community", "inadequate household food security", "underutilization of health services" and "scarcity of water".

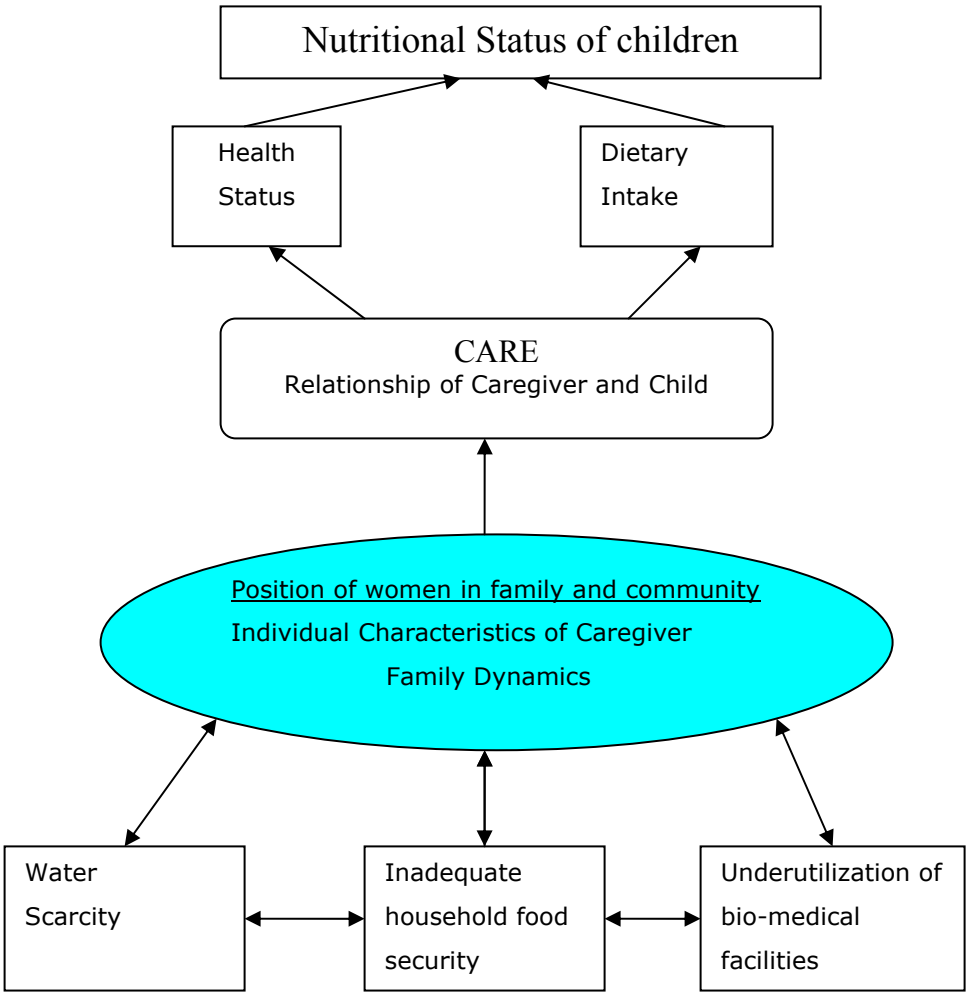
The central and all other issues influencing generative theme was found to be **"the position of women in family and society".** The other issues are not less important but they are always mediated by the role women play in family and community.

In Nepal, women are seen as the main caregivers. Their attitude and well-being strongly influences the development of children. In the case studies presented in this chapter, mothers were found to have highly ambivalent feelings towards their children. The underlying rejection of the child was mostly rooted in autobiographical choices the mother had to make because of prevalent beliefs and values, of female honour and the conflicts particular to the family organization in their respective communities. A woman in difficulties –a young wife with unsympathetic parents-in-law, a wife of a violent husband or with a second wife, a widow or a victim of rape – has very limited options to transform her situation. The resulting anger against other adults who cause her suffering is socially taboo. She may thus target her aggression either at herself or at her children. As one mother who hit her children when she was upset with her mother-in-law explained: "How can I loose my face by being angry with my mother-in-law?" Motherhood confers upon a woman "purpose and identity that nothing else in her culture can", writes Indian psycho-analyst Sudhir Kakar[53]. And yet, the conditions under which many women have to be mothers are sometimes so hard that it is difficult for them to invest their children with positive emotions.

Based on these interpretations a **conceptual framework** (Fig.2) can be constructed that stresses the crucial relevance of a woman's position in her family and community for the relationship between caregiver and child, and hence for the quality of care a child receives. Resource constraints are equally influencing the quality of care. But the exact effect water scarcity or poverty have on the nutritional status of a child is mediated always by the dynamics in a family and by the mother's psychosocial conditions. Our case studies have shown impressively the entwinement of the personal and political, the individual and the social.

[53] Kakar (1997:56)

Fig 2: Conceptual Framework on the causes of malnutrition in Kathmandu



Implications for the Urban Nutrition Project in Kathmandu: A project aiming to improve Knowledge, Attitude and Practice related to nutrition has to focus on the caregivers. They should not be treated as a tool to improve the child's health but rather as the crucial agents of change. Their well-being and especially the well-being and empowerment of mothers must thus be the first preoccupation of a successful program. The Urban Nutrition Project is aware of this dynamic. In home visits and trainings it creates the space for women to

speak and reflect about their situation and to gather the strength to develop strategies for change. In order to expand the support system for caregivers, Sagun has started community-managed child care centers and will be working more with women's groups. Together with these groups, Sagun will intensify its efforts to address the underlying causes for malnutrition.

Sagun has decided to take up the water issue. Social mobilization of families in the wards around this theme will be a new challenge. The underutilization of health facilities is already addressed by Sagun's efforts to improve the capacity of the staff in Kathmandu's ward clinics. In addition, Sagun should try to raise awareness at the Maternity Hospital and the National Children´s Hospital of how the attitude and capacity of their staff works as a deterrent for people to adequately use the health system. Income generation is acceptably considered beyond the means of *Terre des hommes* ' supported nutrition projects. However, it may be possible for volunteers to scout for income opportunities and connect caregivers to these if required.

All staff and volunteers of Sagun are women. It is thus particularly important that they discuss how not only the families they work with but they themselves are inspired, guided and constrained by the gendered matrix of values and beliefs.

Chapter 6 –
The Dynamics of Home Visiting: From Addressing Symptoms to Understanding Causes

6.1 Introduction

If we allow enough time when dealing with families of malnourished children, complex stories unfold. Often it is possible only over several meetings to figure out what caused the frequent illness or the lack of appetite which were the two main reasons family gave to explain why their child was underweight. The visitor has to listen carefully to slowly gain an understanding of the interface of generative themes and idiosyncratic experience and thus the nature of the factors influencing the nutritional status of the child.

As our interest was to find out the situation within families of malnourished children, the visitor knew it was most important to listen and to relate to the mother. The visitor discussed the case with us every two weeks. She described her visit in as great detail she could remember. As we had not provided her any detailed guidelines, her narrative revealed her approach, her understanding, and her difficulties. During the case discussions, we tried to understand together what was happening and what step to take next.

In this chapter we will present a *thick description* of two interactions between a family and a home visitor. Both cases have been mentioned in abbreviated form in the last chapter. The thick description will now give a more in-depth understanding of the entwinement of key issues influencing the nutritional status of the child concerned. With a detailed presentation we also want to show the dynamics of the interaction between the visitor and the caregiver. The case studies illustrate that the central factor in a successful facilitation of a

caregiver's empowerment is a solid relationship of trust between the visitor and the family members.

6.2 The story of Manju Joshi and the family of Gita Lama

When Manju, a staff nurse, saw Gita Lama for the first time, she was 19 months and 8 kg. Her mother Mina (25) reacted very positively to Manju's visit. She immediately explained that Gita had had diarrhea on and off since she was 3 months old. The child passed out everything she ate, either through diarrhea or by vomiting. Whenever the child was sick, Mina bought medicine at the medical shop. She also consulted various dhamis[54]. Once, when Gita got very sick, she took her to the National Children's Hospital, where they did not find anything in stool and blood. According to the mother, medicine had worked when the child had one of her equally frequent ARI episodes, but nothing seemed to heal the diarrhea. From the mother's description of how she administered the tablets, Manju suspected that she may have never let her child complete a full course of antibiotics.

The visitor learned that Mina's maternal home was in the south of the country. She came to Kathmandu a few years ago to find work on a construction site. It was there she met her future husband, a truck driver. It was a so-called "love marriage," i.e., a marriage not arranged by relatives. At the time of Manju's first visit, they had been married for two years.

Mina said she had worked as a labourer right up to her delivery. After delivery, her husband had asked her to stay at home to look after the child. He earned a decent salary and gave her all the money he earned. He worked a lot and was hardly home. This was why they had never visited his or her parents since the child's birth. The husband's family, however, came occasionally to visit. It seems they were very affectionate with Gita as there were few girls in their family.

Mina, her husband and daughter lived in a rented room, which the visitor found very clean, though cold and humid. The mother said that the child didn't like to use a quilt cover at night and that she would take off her warm clothes in winter in spite of freezing temperatures. Manju

[54] Traditional healers

observed that the child was lively and charming and often came to the mother, sucking at the breast for a short while and then moving away. Seeing this, the visitor pointed out that the child needed to be breastfed for a longer time and that the mother should concentrate on feeding the child smaller portions many times a day. The mother complained that the child was not staying at the breast longer and rejected food, however, "when she sees food somewhere, she just takes it and eats it, but when I try to feed her, she doesn't eat." She was clearly frustrated at the child's behaviour and seemed tired of continuing to try. When asked whether the husband sometimes fed the child, the mother said that he came home very late. She said, he really loved their daughter and was upset about her constant sickness and about Mina's seeming inability in caring for the child. He once accused her:"You are killing your daughter."

When Manju reported her first visit to us, we were struck by how talkative the mother seemed. She appeared relieved that someone had come to help her care for the child. She seemed desperately worried about the child's failure to thrive. We also sensed an ambiguity in the mother-child relationship. The child rejected the warm clothes put on her by the mother and had trouble digesting the food prepared by her mother. The daughter's digestive system had become an obsession for the mother, and the inability of the daughter to grow healthy appeared to be the focal point of the family's tensions.

When the visitor returned a week later, Mina happily reported that the child had not had any diarrhea ever since Manju's visit: "It's like magic. She used to spit out everything, now she is eating well." The visitor tried to trace what happened around the third month when the diarrhea started. Mina persisted in saying everything was same. The child seemed to have constant diarrhea for 10-12 days, after which she was o.k. for about 2 days, before the next bout began.
Manju recommended that the mother try out sarbottam pitho, the locally made superflour, as an additional nutritious food. She also suggested that Mina help the child drink boiled water. The child ignored the bottle of boiled water prepared especially for her by her mother and drank unboiled water from the bucket, just as she noticed her father doing.

Our impression was that the visitor seemed to have a hugely calming effect on Mina, who was alone and preoccupied with her worries about the child: Someone from outside had come to help who seemed confident about what to do next - just like a mother.

On her third visit, Manju learned that Gita's diarrhea had come back immediately after she had been given superflour. When the mother subsequently stopped the superflour, Gita reacted with constipation. The child passed stool for the first time in 5 days during Manju's visit. This confirmed our impression of Manju's calming effect on them.

The mother followed Manju's advice regarding boiled water and the whole family now drank from the same bottle. The mother was eager in following all of Manju's advice. She tried very hard to do the best for her child.

Manju asked Mina about the post-natal period, in a new attempt to get the child's history of diarrhea. Mina said that, after returning from hospital, she had to immediately take care of the household chores and was not able to rest. She bled heavily for a month after delivery and was tired and giddy. But it never occurred to her to see a doctor. Manju was shocked and interested in finding out why she didn't go to her maternal home, as is the custom in Nepal for new mothers. Mina said it was because her husband had nobody to cook for him. She said her husband was a hard-working man who didn't go out to drink.

At the end of the visit, Mina told Manju that she had recently decided to visit her mother for the first time since her move to Kathmandu 4 years ago. This confirmed our view that Manju, in Mina's perception, had assumed the role of a supportive adult and Mina was now encouraged to check whether she could gain such kind of support from her real mother.

First weighing session since the visits started: Gita showed an increase of 500 gr.

One day after weighing, Manju dropped by to meet Mina's husband. He said the child was sick all the time and that made all of them quite frustrated, tired, and tense. He expressed approval of Manju's visits and said the child showed a slight improvement since she came. He could not talk to her for long as he had to return to work.
Manju heard from other people that Mina was not mixing much with other renters in the same house. She kept to herself, staying with her daughter.

Two days later, Manju returned for her regular visit**.** Mina was tense. Gita had had a very severe episode of vomiting and diarrhea. They had

not gone to the hospital as her husband had refused to accompany her. Mina then bolted the door and told Manju more about him, saying he was a womanizer and drunkard before the marriage. She had never wanted to marry him, but her friends convinced her to do so. She talked about her difficult pregnancy when he "was using all the money on girls." That was why she had to continue working on the construction site until her labour pain started. When she went looking for him to take her to the hospital, she had found him with a prostitute. - Her brothers wanted her to abort the child and return to the family, but she refused, set in her belief that it was impossible for a woman to live a decent life after having been with a man.

After Mina delivered their daughter, he changed. He began to give her all the money and to stay at home in the evenings. She distrusted this change though. That may have been why she never left the house to go to her maternal home or elsewhere. She was anxious that he would go back to his old ways. During this visit, however, Mina told Manju of her determination to visit her mother. She had asked one of her relatives to keep an eye on him while she was away.

We were overwhelmed by this unexpected change in the narrative. We also decided it was high time a doctor examined Gita. However, before this could happen, Mina and her daughter left for the village.

They returned after 19 days. Mina expressed her disinterest in village life and her maternal home and said she was happy to return. Gita, however, had been very well, she said. During their travel and stay in the village, the child had eaten with appetite and never had any diarrhea.

On her 6th visit, Mina confided in Manju the circumstances of her marriage. While she lived alone, rumours had circulated that she saw men in her room. She was very hurt by such talk and had defended herself. She never wanted to marry her husband, whose character she was aware of. But she was forced into marrying him by her friends who believed that she was the right person to bring him to reason. They locked her up with him for a night. He raped her, and she felt she had to marry him as she had lost her purity: "Afterwards, everybody knew about it and I decided to continue staying with him, otherwise people would have blamed me for staying one night with a driver." As a woman living alone, she was thought of as immoral. In this atmosphere the people she trusted forced her to live up to the image. Her only way of dealing with her shame was to marry the man who had made her into

a “loose” woman. The circumstances of her marriage may well explain her ambivalence in her relationship to her daughter that struck us from the beginning. We now also understood why she kept away from people. While she talked, her daughter grew restless and wanted to leave the room. For the first time, Manju saw Mina open the door, allowing the child to play outside by herself.

After Manju’s report of this visit, she told us she did not want to go back to Mina. She didn’t know what to talk to her about and one hour was far too long for a visit. She was also scared that the community “may do to me what they did to Mina,” as they might link the inexplicable ups and downs in the child’s health to her visits. They may regard Manju as someone who did magic and had to be punished. We concluded that the intimacy of the situation and the mother’s strong emotions may have scared Manju. Our acknowledgement and interpretation of her fears greatly relieved Manju and she was able to continue the visits.

2nd weighing session: Mina lost 100 gr.

When Manju came a week later, the mother seemed upset that her child had lost weight. The child had a bad nightmare and screamed in her sleep after the weighing. She had diarrhea again and rejected all food. Mina said:”In the village, my daughter was red in her face and healthy; here she looks skinny and pale.” The mother agreed with Manju that it was high time to take the child to the Children’s Hospital for a check-up. Was Gita’s weight loss and her nightmares connected to the feelings stirred up while the mother confided the circumstances of her relationship to her father? Or had her weight loss caused the mother so much anxiety that the child reacted with nightmares and diarrhea?

On Manju’s next visit, she was told that the child had been sick with ARI and diarrhea, but the father had disallowed his wife from taking the child to hospital. He felt going to the medical shop was enough. Manju explained how the drugs had to be taken and now the mother realized she had never given a full course of antibiotics and concluded that this may have been why Gita had never really gotten better. She was even more resolved to bring the child for a full screening to the hospital and set a date with Manju. The mother was determined to act on her own and to not listen to her husband’s advice. - At the end of the visit, Mina told Manju of her plans to visit her husband’s family in the village. If she liked it, she would stay there because she was now sure that the child would not get better here. Mina left with the girl without a

thorough medical screening, but returned after 10 days. The child had been very sick. The medical check-up revealed a minor infection. Because the mother had done everything right, was giving Gita rehydration solution and feeding her appropriately, the child had not lost any weight as was evident from the third weighing session.

Mina seemed happy and energetic. She had liked the village and "the house was stocked with wheat and there was plenty of agricultural land. I am very relieved. If my husband mistreats me, I know where I can go." She said she wanted to place her daughter at Sagun's child care centre and look for a job. She asked Manju to speak to her husband who didn't agree. Mina had become much more confident, assured that she had a place if things became unbearable. She tried to achieve greater autonomy by creating space between herself and the child and with her plans to earn her own money. The husband, sensing this change in her, was trying to keep her under control.

The research ended before Mina realized her plans. We decided that Manju will continue visiting her with the intent of helping her and her husband reach a compromise that would allow Mina to reenter the world and reconnect to people.

6.2.1 Key issues for the malnutrition of Gita Lama

Our assumption is that Gita's constant sickness was a reaction to her mother's ambivalence towards a child born as a result of a rape. The mother dealt with her shame by marrying the perpetrator. By this act, she not only lost her self-respect but also what little autonomy she had enjoyed before her marriage. While the mother never expressed negative feelings toward the child, her ambivalence was evident right from the first visit. She seemed desperate, even obsessed with the child's feeding patterns and digestion. The child, in turn, rejected food prepared by her while eating other food. Her response, according to our hypothesis, was directed at her mother's underlying rejection of her. Her husband's comment that she "was killing her daughter" seemed very strong. It was somewhat surprising that Mina repeated it to Manju during her first visit.

It is possible he sensed his wife's ambivalence toward his daughter and realized that she disliked herself in the baby.

Another important cause of the child's constant sickness and malnutrition was the misapplication of drugs bought at the medical shop. Repeatedly, the girl took antibiotics but never correctly. Neither was the mother ready to bring the child to the clinic or for a thorough check-up. This pattern was repeated while Manju visited. Each time a medical check-up seemed indicated, something prevented her from following through. Certainly, this was connected to the experience that not even the hospital was able to diagnose any pathological problem so why bother and travel across town while it was easier to just buy the medicine next door. But again, this failure to bring the child for thorough check-up could also have been an expression of the parent's ambivalence towards the child.

Finally, the mother isolated herself because of her shame. She locked herself into a small room with her child and her worries. She didn´t go anywhere and kept the child at her side all the time – only once did Manju see her let the girl out of the room by herself, significantly while she was finally able to talk about the circumstances of the child's conception. This incredible physical closeness might have reinforced the child's sensitive reaction to her mother's attitude to her.

6.2.2 Key situations in the interaction between Manju and Mina Lama

The first visit is always a *key situation* in the interaction between family and visitor. According to the "Lexikon der Sozialpaedagogik und der Sozialarbeit" (2000), the main function of such a first interview is to establish a relationship

of trust. The client should be able to express his or her concerns, while the social worker or, in our case, the visitor would, withholding judgment, listen to get an initial overview of the situation.

The first visit was handled well by Manju. She allowed the mother to bring up whatever she felt was important and in this way got a good overview of the situation**.** From the first visit, Manju was able to establish a good relationship with the mother and to deepen it in the course of the following visits. That allowed Mina to open up to her relatively fast. Being able to talk about the rape and what the marriage to the father of the child meant to her created space for Mina to reflect on her situation and to gather energy and courage to go out and assess her options. In the end, she had a possible escape plan but also resumed hope that she could improve her situation while continuing living with the father of the child. She gained back some self-confidence and was trying to gain back some of the autonomy she had enjoyed before her marriage.

Although, all these developments helped Mina to control her ambivalence towards the child, the love-hate relationship to her daughter can not be resolved so easily. However, talking about it to Manju helped her; after having been able to express her ambivalence, she didn't need to act it out. She was now able to apply the care practices she had been taught by Manju to provide consistent good care for her daughter.

The basis for the process Mina was able to go through in just a few months was the relationship between her and Manju. Mina trusted Manju and was thus able to feel secure enough to start talking about her traumatic experience and to venture out to assess her options.

A *key situation* in the development of the relationship between Mina and Manju was the moment when Mina confided the circumstances of her marriage. Manju had difficulties to cope with the shame and the fear triggered by Mina's disclosure that she had been raped and was living with her persecutor. The fear of being sexually violated is real for women in any society, and in Nepal it is real that many then have to marry the man who caused the violation in order to save her and her family's honor. Manju's identification with Mina's shame and the awkwardness of knowing so much about her became too strong for Manju. Avoiding Mina by not continuing with the visits seemed the only way out. When we helped Manju to interpret and understand why she felt like breaking off the contact, she was relieved - and was able to continue.

The visitor should have the chance to discuss difficult situations with a supervisor. It is known from therapies and counseling situations that we get entangled in our own projections and emotions when dealing with emotions of others. And this is even more so for counselors who are faced with similar experiences as the person being counseled. Women in Nepal all live in a society with very strict views on what is honorable. They all know that in case of crisis, their personal interest and well-being will have to be sacrificed for the interests of their family or the society in general. They, thus, often find it very difficult to keep a good enough closeness to the the mother visited, i.e. to maintain the balance between identifying themselves too much so as to lose focus nor distancing themselves so much that they lose contact.

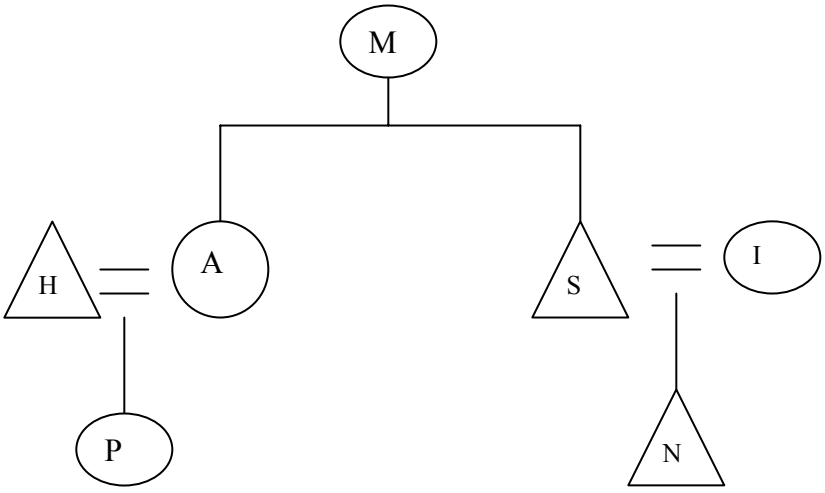
6.3 The story of Shanta Poudel and the Shahi-family

Shanta, a nurse and nutritionist with many years of working experience in institutions and in the community, was assigned to find out what

happened to Parvati Shahi. The girl had been brought for growth monitoring when she was 24 months old. She weighed 8.4kg, was thus below 80% of the standard weight/age. After this one attendance, Parvati did not come back.

Shanta visited Parvati's family over four months. The family dynamics were complicated and at times confusing. Many different strands were braided into each other and the visitor was able only slowly and step by step to unravel them. We will try to give an insight into this process and yet to simplify enough for readers to follow. To help the orientation, Fig. 3 presents a "who is who" in the Shahi-family.

Fig. 3: The Shahi Family



M = Mother

A = Anita
H = Anita's husband
P = Parvati
S = Shiva, Anita's brother
I = Ishori, the daughter-in-law
N = Nirmal, Ishori's son

The first contact between Shanta and Anita (24), Parvati's mother, was not very successful. Anita responded very reluctantly to Shanta. Put off by these negative signals, Shanta didn't explain properly why she came to visit and immediately began with rather inquisitive questions. From

Anita's sparse answers, it seemed that her living arrangements were very unusual for Nepal. She lived in her maternal home and not with her in-laws in a joint family or with her husband in a nuclear family. When Shanta asked who lived in her maternal home, she got the answer: Anita, Parvati, Anita's mother, Anita's brother and his wife. Anita reported that the child didn't eat properly. Shanta got the impression that Anita was pregnant and asked about it but Anita denied it.

When we reviewed this visit with Shanta, she expressed her disappointment. She was used to establishing good rapport with mothers quickly but Anita had been distant with her. She blamed it on Anita's ethnicity. "She doesn't have the social discipline, no warmth," Shanta complained. "Newars are often like that. Not very civilized. They are suspicious and don't allow you to come close."

A week later, Shanta found Anita sitting on the terrace with a neighbour. When he found out that Shanta was a nurse, the neighbour talked about his daughter who was in psychiatric care. Shanta's advice seemed to impress Anita, who now better understood who Shanta was. She invited the visitor to look at her mother who was in bed with asthma. Both women appreciated Shanta's instructions regarding drugs and diet. Shanta had managed to gain access to the family by her knowledge and status as a nurse.

At the 1st weighing session after the visits started, Parvati registered a gain of 100 gr.

When Shanta complemented Anita on the weight gain of her daughter, she was told that the girl was now eating as Shanta had advised. But not for long: In the next visit, Anita repeated her complaints that the child was unwilling to eat. It remained a pattern in most visits that Anita complained about the girls lack of appetite and Shanta responded with a 24-hours-recall of the food intake. Each time, she afterwards assured Anita that her daughter seemed to receive enough food. Shanta was puzzled, she couldn't figure out what the problem was.

Between the third and the sixth visit Shanta was told more about the family set-up: Anita's mother mentioned that her daughter had not been able to adjust in the house of her husband and had thus moved directly back to the maternal home after she had delivered Parvati at the hospital. Shanta did not further explore this issue. Instead, she continued to concentrate on technical issues of feeding. One day,

Shanta discovered that Anita had a room on a different floor of her maternal home where she lived with her daughter and her husband. Shanta was surprised and Anita seemed embarrassed and reluctant to talk about an arrangement that was disapproved off by the community[55]. However, Anita also said that the girl "likes her father but he doesn't play with her. I think my husband goes to his family during the day." She seemed to be bothered by his loyalty and attachment to his home. Shanta didn't react to this attempt of Anita to disclose more about her problems. Instead she returned to the feeding pattern of the child.

Sometimes during these visits, Ishori, the daughter-in-law, was present. Shanta observed that she was treated like a maid who prepared tea for everybody, who didn't talk and sat on the floor while all the others sat on chairs. Shanta felt sorry for her and tried to draw her into the conversation.

2nd weighing session: Parvati increased her weight by 500 gr.

Once, when Shanta had just entered the house of Anita and her family, she was called by a volunteer to see a sick mother in the neighbourhood. When she returned to the Shahi-family a week later, the women asked her about the patient she had seen. After hearing that the neighbour had delivery related complications, Anita revealed that she might be pregnant, though the reports from two different clinics a few months ago had been contradictory. She asked Shanta to check and, to her surprise, Shanta discovered that Anita was about 28 weeks pregnant[56]. It seemed rather strange that Anita, 7 months pregnant with her second child, had asked as though she was uncertain about her status. Was it an expression of her ambivalence about her pregnancy? - For the rest of the visit, the women discussed the arrival of the new child. Shanta mentioned that Parvati, the little girl, should be prepared for the birth of her sibling as she may get jealous. Anita and her mother commented that they had never heard of such a thing. Then the conversation shifted to the role of daughters-in-law**:** Anita declared that daughters-in-law should be treated properly, like daughters, probably referring to her own negative experience in the house of her husband. Shanta, thinking of Ishori, the daughter-in-law of this house, stressed the same point. The mother, surprisingly, agreed with her and said she would now treat her daughter-in-law better.

[55] According to Newar FGD participants it is absolutely unacceptable that the husband lives in the house of his wife's parents.

[56] In Nepal, it is often not easily visible that women are pregnant as they put on very little weight and also wear wide clothes.

On her 7th visit, Shanta met the daughter-in-law alone at home. In the course of their conversation, Shanta discovered that she had a 7 months old son. He looked "very well, very fat and big". According to Ishori, he slept the whole day but was awake at night and wanted to play. Ishori cried when she explained she had no time to look after her child during the day. Shanta discussed this issue with Anita and her mother who explained that the little boy was given a local mix of herbs to make him sleep during the day. Shanta advised them to stop this practice gradually as it was harmful for the child. The boy was not underweight but we were sure a developmental problem would come from his not being allowed to be up during the day and to participate in the family activities. Instead, sedated, he slept only to wake up for the meals and was judged by everybody as very nice and fat – fat children are rare and are highly appreciated.

Why Ishori had to deny the existence of her child is unclear. A hypothesis could be made that it was connected to the unusual arrangements of this family. The arrival of the first child, especially if it is a son, normally enhances the position of a daughter-in-law in the family, making her reluctant to remain her mother-in-law's servant, as is the norm when a young woman first comes to the house of her husband (see Chapter 5). In this family, however, the mother treated her son and daughter as children and not like married adults. Thus, there was only space for a maid, not for a daughter-in-law or a grandson.

Parvati, Anita's daughter, had been sick for a while and lost weight. Shanta advised on how to treat the child during sickness and invited Anita to bring her for medical screening to Sagun. Anita was happy to take the child to a place she trusted. She and her mother had repeatedly complained about various health facilities. Both women had had bad experiences with clinics and doctors and didn't trust them. Anita also didn't like that the staff of the neighbourhood clinic had asked her intrusive questions about her status as a run-away-wife. **Even after** Shanta had discovered Anita's pregnancy and advised her to go for ante-natal check-up, she was hesitant to go to the hospital, claiming she didn't trust the doctors.

3rd weighing session: Parvati who had been sick for many days, lost 500 gr.

Anita still often complained about her child's lack of appetite. Shanta asked her when she had first noticed the eating difficulties of her daughter and Anita mentioned the month just after the beginning of her pregnancy. This was certainly no coincidence. It could be that the girl had noticed the changes in her mother and the stress related to it. Anita was on contraceptives and had not wanted to become pregnant. She also must have been quite unsure what was happening to her judging from the fact that she went to see two different doctors about it. Or, as an alternative explanation, Anita who lived like a daughter in the house of her mother connected the eating problems of her child to her pregnancy and thus to her ambivalence about her role as a mother and wife.

When Shanta made her 10th visit, the mother called Ishori, her daughter-in-law, to join the group. This was a clear change of practice as before, Ishori had been more of an invisible presence to whom only Shanta paid attention. It seemed that Shanta's discovery of the grandson and her open sympathy for Ishori had changed the balance in the family. The daughter-in-law brought Nirmal, her son and Shanta held him on her lap. Immediately, Parvati, the little girl also wanted to be on Shanta's lap. Shanta talked about sibling rivalry, saying that people often thought children didn't understand anything but instead, "children are like gods and they sense, sometimes before the doctors know, about their mother's pregnancy. Something clicks when their mother is pregnant." This interpretation was indirectly accepted: The mother recalled some events from Anita's childhood which confirmed what Shanta said. Then the daughter-in-law asked why her child didn't sleep at night. Shanta explained that parents needed to give children time during the day, children needed adults to play with them and talk to them. Anita was surprised and asked: "What should we talk to children about?" Shanta explained that contrary to what most people believed, children understood many things. "They even know whether their parents love each other." Anita immediately responded: Was this why Parvati had difficulties sleeping after she and her husband had one of their frequent arguments? Also, Parvati lost her appetite when her parents fought. Anita said the reason for their arguments was that her husband listened to his mother too much. During her 10th visit, Shanta understood that the girl's eating difficulties were related to family tensions.

In the following visits, Shanta learned more about the nature of the fights between the husband and Anita and she offered her advice on how to deal with it. She was pleased to see that Anita took over

household chores from her sister-in-law, and that Ishori's son no longer slept during the day but played with Parvati. The two children were fed at the same time.

4th weighing session: Parvati gained 400 gr.

Towards the end of our research period, Shanta noticed TB-symptoms in Ishori and strongly advised the mother to send her daughter-in-law for medical screening. The mother wanted to call Ishori's family to bring her to the hospital. Shanta opposed and pointed out that it was Ishori's husband's responsibility to accompany his wife. The mother said she had never asked her son to do anything for Ishori. Shanta gave her a little lecture that she had to prepare her son for the role of the head of household. The mother obviously had difficulties accepting that she had two adult children, a daughter-in-law and grandchildren. She had not only denied the presence of her grandson but, as Anita now told Shanta, she also didn't relate to her granddaughter: Anita explained she would rather not leave Parvati at home when she had to go to hospital for delivery because "Parvati doesn't like her grandmother". Shanta felt confirmed in her observations of the distance between the girl and her grandmother. The grandmother never addressed Parvati nor interacted with her.

The women started to understand that the roles in the household had to be reorganized. In the 12th visit, Ishori's husband was present. Together, they discussed how the family could manage the care for Ishori who was now confirmed to have TB. Ishori's husband expressed his happiness about getting involved more. He said his mother had before not allowed him to participate in the household affairs.

That was the last visit within the timeframe of the field work for this study. We decided that Shanta would continue visiting a few more times. She wanted to meet Anita's husband as the Shahi women had asked her to. He had been absent except in the complaints of the women. Shanta thought it was important to clarify his responsibilities for his wife and children and to work towards establishing him and Anita with Parvati and the unborn baby as a family unit.

6.3.1 Key issues in the story of Anita and Shanti Shahi

At the heart of Parvati's eating disorders was the role confusion in her family and the tensions arising from that. Her parents had not managed to change their role from that of children to parents. They had failed to find a personally and culturally acceptable way of establishing a family unit. While the husband was against breaking away from his joint family to set up a nuclear unit with his wife, Anita had retreated to her home, to the role of a daughter. Her ambivalence towards being a wife and mother was evident from the fact that she denied her pregnancy for seven months.

Her mother, who was at the centre of this confusion, refused to accept that her children were grown up and married adults with responsibilities for their own partners and children. She treated her daughter-in-law like a maid and denied the existence of her grandson. When it was impossible not to notice the TB of Ishori, the mother wanted to shift the responsibility for her care to Ishori's family of origin.

The nutritional status of Parvati was further influenced by the family's care practices. They didn't know how to feed her during her sickness and were obviously unaware of children's emotional needs. Thus, they were surprised to hear that children needed stimulation and shouldn't be sedated for the sake of adults' convenience.

Another key issue was related to the generative theme of underutilization of bio-medical facilities. Negative experiences with health facilities and distrust of health personnel played a role, though minor, in Anita's decision not to go for ante-natal check-up. Her attitude toward her own pregnancy had greater significance. Certainly, the fact that the visitor was a nurse gave her weight and authority in a family that had such negative experience with health

facilities and at the same time a great need for health information and health counseling.

Anita's shame about her family situation led her to isolate herself and her daughter. Like many other mothers we visited for this study, she led a very secluded life, limited to her immediate family. Her confined life did little to help her disentangle herself from a complicated and unsatisfactory social situation. Neither did it help her daughter.

6.3.2 Key situations in the interaction between Shanta Poudel and the Shahi-family

In this case, the *key situation* "first visit" was rather unsuccessful. Shanta took personally Anita's resistance in talking to a stranger about her child and her own situation, and she attributed it to Anita's ethnicity. This prevented her from seeing Anita's behaviour as an expression of an individual attitude that might reveal something about her specific circumstances and the dynamics of her home environment. As Shanta was at that point unable to see the person behind the social insult, she resorted to an authoritarian tone and didn't explain why she was visiting her. Thus, Anita did not know who she was talking to and was, understandably, reluctant to disclose information. However, it is interesting that even in that first session, there were hints of the central conflict in this family, more by what Anita omitted to say than by what she said: She didn't mention the presence of her husband or Ishori's son in the house, and she denied she was pregnant.

Another *key situation* in the development of the relationship and in the understanding of the case was Shanta's reticence to respond to the family's attempt to explain their situation. Twice, when the central conflict between

Anita and her husband came up, Shanta changed the subject by asking Anita technical questions – the birth weight of the child (low birth weight as a factor in malnutrition) and her husband's salary (household food security).

Shanta's hesitancy to take up the issue may have been connected to an insecurity about the role she was supposed to play as a home visitor. As a health worker, she was accustomed to look for medical facts only. For this study, she had been asked to understand the situation in the family. This task was unfamiliar for her and she was unsure as to how to go about it. If she went as a social visitor, she would be awkward if people she hardly knew disclosed emotional information and would probably have avoided the subject as she did in her visits. Moreover, it is difficult for a person untrained in counseling, to deal with the emotions of the families they are visiting. The visitor needs support in defining and filling the role of a professional who is neither just a health worker, concerned with technical issues to which she offers advice, nor a relative who is part of the family affairs.

Shanta saw the role confusion in the family and directed herself towards its clarification: She took side with the daughter-in-law, though skillfully, as not to put off the others; she also made the mother understand that the husbands had an important role to play**.** Shanta's interventions changed the balance in the family with a positive impact on the children´s health and nutritional status.

6.4 Conclusion

The case studies illustrate the psychosocial approach. The caregivers' personal history and experience are as much taken into consideration as are the resource constraints, the level of knowledge about care practices and the conditions of the social and cultural context. In both stories, the **role of women** in family

and community, the self-expectations of women and the expectations that others had of them, played a major role in the caregiver's **attitude and relationship to the child**. Both mothers had ambivalent feelings for their children.

The description of the process showed how complicated it often is to unravel the story behind a child's malnutrition and lay the ground on which change can start to happen. In this effort, much depends on the development of the **relationship between home visitor and caregiver**. A reliable relationship allows the caregiver to talk about her worries and reflect her situation and it allows the visitor to form a hypothesis on what influences the child's nutritional status. The framework of the relationship is what makes it possible for the caregiver to hear, accept and perhaps integrate what the visitor advises regarding care practices.

In the development of the relationship between visitor and caregiver, we identified the following *key situations*:

- **The first visit**: It is particularly important for a visitor to understand the significance of the first visit. The aim of the first meeting is to form a preliminary diagnosis and to establish the relationship with the caregiver. To achieve this, the visitor must allow the mother to talk about the issues she chooses. The visitor should not be on the lookout for technical information only but should consider all the hints and clues to what lies beneath the insufficient care practices.

- **Shame and fear**: Intimate and difficult stories are sometimes hard for visitors to deal with. The suffering of another woman may trigger fear or shame. If the visitor resorts to blocking off emotional information

that she cannot handle, the relationship may remain superficial. This can extend the time for the problems at the heart of the child's difficulties to be understood, or, it may lead the visitor to sever the contact, as it almost happened in the case of Manju.

- **Case discussions and supervision**: A regular discussion of the dynamics of a visiting process with someone who is not part of it will help the visitor to better understand what is happening to herself and to the caregiver. Supervision will help the field worker to see through some of her entanglements with the emotions of the caregiver, and it will deepen her understanding of the different factors influencing a child's nutritional status. Supervision not only contributes to a more effective visiting process, it also supports the skill development and analytical capacity of the field worker. The psychosocial approach to malnutrition is initially unfamiliar for health personnel and so is the role as a facilitator of empowerment. Both concepts can not be sufficiently understood in a workshop situation but have to be practiced and tried. Supervision is an important tool in this learning process.

- **The time factor:** The home visiting process for this study was defined as a learning situation. We wanted to understand better the context of malnutrition and we wanted to observe what was happening between the visitor and the family. Thus, we didn't fix the number of visits before closure neither did we define what needed to be achieved before the case could be closed. In the context of a normal project situation it will be important to define the setting more clearly, keeping in mind how long it takes to establish a relationship of trust or to understand the mostly complicated family situations. In an evaluation of effectiveness of home visiting programs for pregnant women and

parents of young children, it was found that in one of the particularly unsuccessful programs, the number of home visits for pregnant women was reduced to four. In a program where changes have been achieved, the mother was visited eight times. Most of the ineffective programs had scheduled four or fewer than four visits[57].

- **Closure**: A *key situation* in each home visiting process is the closure. In the above discussed cases the process did not reach this point. We had agreed at the onset of the research that we would stop the visits if we could be sure that a change of care practices had been reached and was sustainable. We decided that the indicator for success was the child's gaining weight in two successive months. But we had to drop this indicator as it became apparent that the mother may have understood and was ready to change but the changes had not yet been represented by continuous weight gain or that the child gained weight but we were not sure whether it was really connected to improved conditions for the child. It seems that clear and reliable indicators are hard to identify for the closure of a visiting process and that much depends on the visitors interpretation of how sustainable the change is that has been achieved. The less trained a health promoter is, the more difficulties she will have if not given clear guidelines and indicators. This will be discussed further in the last chapter. In any case, closure should be a deliberate decision between the visitor and the caregiver rather than a unilateral decision by the visitor to stay away. The relationship of trust that evolved between visitor and caregiver requires an adequately prepared and discussed separation in order not to leave the caregiver disappointed and angry of having been left behind. An

[57] Olds et al (1993)

unreflected ending may negatively affect what has been achieved in the process.

These key points will be further analyzed in the following chapters.

Chapter 7 –
The Challenges of Facilitating Empowerment

7.1 Introduction

"*Listening to mothers*" may serve as Sagun's motto in dealing with malnutrition. It is a metaphor for the process of discovering what is at the bottom of the child's malnutrition. But *listening* also entails entering into and building a relationship of trust between the visitor and the caregiver, with the clear objective of enhancing the caregiver's confidence and empowering her to choose a course of action that leads to an improved situation.

Not all of the 22 health promoters were as successful in implementing this approach as the visitors we presented in the last chapter. Initially, most action research participants were reluctant to visit a family regularly over a longer period of time. But during our review meetings, we sat together to identify and discuss the reasons for their wariness regarding home visits. Gradually, the participants changed some of their attitudes and went on to acquire certain skills. As the response from the families grew positive, the motivation to continue visiting increased. At the end of the 4 months of action research, only two visitors still felt distant to the families or unable to listen to the parents. The others became convinced that investing energy into establishing a sound relationship with the clients was key.

In this chapter, we will discuss the difficulties of health promoters as they listen and try to understand what the families have to say. These can be structured into three problem areas which are closely interlinked:

- The **professional identity of health promoters** does not support the role we encouraged the visitors to play. Generally, health personnel is trained to consider medical aspects of nutrition; other factors

influencing malnutrition are either unknown or neglected in the assessment of the situation.

- Listening and understanding requires **communication skills**. Learning such techniques is often only a marginal aspect of the training for health promoters. But integrating communication skills is not only a matter of having the right training, it is affected by the way people in a community generally communicate with each other.
- The **socio-cultural identity** of home visitors as members of a certain caste, an economic group, or as a woman, strongly influences her relationship to the caregiver. Even if a health promoter is trained well, her value system and self-definition may counteract her knowledge about communication.

In this chapter we will describe the situation of home visitors in the context of the Urban Nutrition Project of Kathmandu. We believe that the obstacles identified can be observed in most nutrition and health projects in the country.

7.2 Professional identity of health promoters

Healers and learned people receive considerable respect and even devotion from a population with an illiteracy rate of 57% for women and 34% for men[58] and a lack of adequate health care for a majority of the poor. A "doctor sahib" is highly revered and the allure he enjoys also extends to nurses and other members of the health system. Even a volunteer who has learned basic health information in 8 training sessions is looked up to by her neighbours and gains pride and motivation from being associated with the respected health profession:

[58] Central Bureau of Statistics (2002)

> "In our area, people were not showing children to each other. Now they know me. They trust me and come to me. Even for minor problems I can help. They call me their nurse."
>
> "Many people in the neighbourhood now know me and say: she is our doctor. I like that."

Not only are doctors and health workers respected for their knowledge and healing skills, they are often seen as intimidating figures, to the extent that many ordinary people even keep away from what they view as their superior attitude and aggressive behaviour (see chapter 5). I have rarely observed a health worker or a doctor who explained anything to a client. Representatives of both traditional and modern healing systems do not regard it part of their role to explain their art to patients. Until recently, the same was true for medical practitioners in the West.

The communication is by and large one-sided. The health workers ask questions to arrive at the diagnosis and then dispense advice. "Dialogue between patient and health worker is scarce and fragmented, whereas a chronic condition demands continuous interaction and negotiation," writes Paul Bossyns, who discusses the difficulties of health workers with the complexities of malnutrition in Niger and comes to a similar conclusion[59]. Giving instructions is what health personnel learn in their training and from their own personal experience in and with the health system. Indeed, it is what many health practitioners seem to like about their job:

> During the second visit to the family, the visitor, a nurse by training, met a neighbour who desperately sought advice as to what course of action to pursue regarding his mentally ill daughter. The visitor told him where to take the girl. Her comment afterwards: "I really like to meet patients and talk to them. I can give advice. I like to tell people

[59] Bossyns (2001)

rather than listening. That's the opposite of what we should do in this programme!"

Another nurse who participated in this research was frustrated and angry because she was discouraged by us to act like a typical health worker. She was confused what it was then that was expected of her: "We don't give anything, I feel bored with that. I feel awkward, I am not enjoying it. The mother seems o.k. but I don't know what she really thinks." It turned out that during her last visit the child had searched the visitor's bag for sweets. "When we visit our own relatives, we always bring something. But for this type of visit, we can't do that. I searched the bag for something to give. I didn't know what to do."

Understandably, the visitors feel insecure. They are unsure how they can legitimize their presence if they cannot act as a health worker might be expected to. At the same time, they are not friends or relatives who have come for a social visit.

The psychosocial approach envisages the visitor as a facilitator of empowerment. The dynamics of empowerment, which include listening, understanding, building trust and supporting people to take action rather than giving them something or telling them what to do is neither part of an average health worker's personal experience with health or other services, nor part of their training. It is an alien concept for them and thus clearly not something they can learn in a short workshop. Rather, empowerment and participation has to be learned through experience and reflection upon it.

Most health promoters also find it an unfamiliar concept to consider psychological and social factors when assessing the situation of a malnourished child. Health staff have been trained to think in biomedical and epidemiological terms. Nutrition training manuals focus heavily on disease and feeding. The curriculum for a psychosocial approach to malnutrition would have to be broader and prepare health promoters to connect, for example,

information about the child's reluctance to eat with information on how the child is fed, as well as with the family quarrel the mother mentioned or the visitor's observation that the caregiver didn't pay attention when the child asked for food. But making these connections and combining observation with knowledge was found to be difficult for the participants of this study and also for health workers we observed in other projects. In the health system, professionals are used to thinking vertically. But when dealing with the complex condition of malnutrition, it is vital to think more holistically. This poses an uphill struggle because a complex understanding of illness across the boundaries of well-defined categories is not part of the approach as generally practiced by health workers in Nepal. The challenge of combining facts and to insist on looking more closely or questioning the status quo is also entirely at odds with the "learning by rote"-model common in the school system of Nepal. Freire called it "banking education," because the teacher deposits knowledge in the students: "The teacher teaches and the students are taught; the teacher knows everything and the students know nothing; the teacher thinks and the students are thought about; the teacher talks and the students listen – meekly…."[60] Given such a learning environment it is understandable that health workers initially may be disinclined to adopt an empowering approach to health education.

7.3 Communication and education skills

The ability to facilitate empowerment is not only related to the professional role of the visitor, it is also connected to the ability to communicate well. When we analyzed the interactions between health promoters and families, we realized that more effort had to be invested in upgrading their communication

[60] Freire (1970:59)

skills. In the crucial first meeting between visitors and caregivers in particular, many communication key issues became apparent.

First visit: The first interview is a *key situation* in every counseling process: if the caregiver understands the purpose of the visit and is able to connect to the visitor, she will bring up or allude to issues important to her. This will allow the visitor to form a first hypothesis as to why the child is malnourished. This process can be either furthered or hindered by the communication style of the health promoter.

"I was confused and frightened and not very comfortable," said one volunteer after her first meeting with the caregiver, echoing what many of them felt. All visitors reported that they were anxious whether the family would be welcoming and would respond or whether the situation would be embarrassing and awkward . Three months later, we asked the volunteers to describe a positive and a negative situation in their visiting process. Although the event was long past, 75% of the volunteers again referred to the first visit.

All first interviews in counseling processes are marked by a certain anxiety connected to the unknown and unfamiliar. Moreover, the volunteers felt particularly insecure because before joining Sagun, they were never asked to take the initiative in contacting people who were not related to the family. Interestingly, the volunteers who had to visit a neighbour felt equally uncomfortable. Until now, they were just neighbours; now they had to visit in a new and public role without being quite sure what was expected of them. In that situation they often resorted to being formal and even authoritarian, assuming that was expected.

The following narrative of a first meeting between a volunteer and a mother points to key issues that need to be addressed when teaching communication skills.

> Volunteer S: "The first time I went she was washing clothes. First I did Namaste and mentioned my name. Then I said that I want to talk to her about her child. I asked: What do you feed your daughter? She said biscuits and so on. I saw her buying biscuits. I said to give jawlo. But she doesn't listen. She gives what adults eat, no special preparation. They don't have an economic problem. But the woman sleeps and the children are dirty. I told her to keep her child clean but she doesn't listen."

The visitor did not introduce herself properly or explain the purpose of her visit. She offered advice before she had a full picture of the situation. She was also quick to lay blame on the mother for being lazy and stubborn.

Namaste and the problem of politeness: Volunteer L. first described how she greeted the mother. Each time a staff or volunteer told us about a visit, she never forgot to mention that she had done *namaste*, the local form of greeting with palms together in front of the chest. In the beginning, we didn't pay much attention to what appeared like a formality, comparable to saying "good afternoon" to an English-speaking client. Until one day a volunteer described her first visit in the role of a volunteer to a neighbour she had known for many years: "The mother is called Sabitri Pandit. I already knew her, she was not a stranger. Despite that I introduced myself by telling her my name and doing namaste." It seemed strange that she would introduce herself in so formal a manner to an old acquaintance. Now sensitized, we began to notice hints that doing *namaste* didn't seem natural to many of them. Why otherwise would they always mention it so dutifully, as if it was a particularly important or memorable part of the visit?

In a training session we asked the staff what they thought about doing *namaste* to the mothers. While some thought it proper to begin their home visit with such a greeting, many felt awkward about it and were relieved the topic had come up. Among neighbours and friends, the most common greeting is: *"bhat khanu bhayo?"* – "Have you eaten your food?" or simply: "*araame*?" – "well?" One staff member said she only learned to do *namaste* when she began her training as a nurse. Another participant was worried that people in the community might interpret such a formal greeting as making fun of them, making pretence of reversing the real hierarchy between the visitor and the mother. Traditionally, *namaste* is done to pay respect to gods and elders.

The necessity of showing respect to clients and therefore to do *namaste* is reported by almost all development personnel we ever talked to. Countless anecdotes are recounted about how this form of greeting was dutifully carried out in the most inappropriate situations. A field worker who goes about his private business would greet with an informal "*khasto chha*?" – "how are you?" But as soon as he comes back in the capacity of a development worker, he would fold hands in front of the chest and say *namaste* to the same people.

According to one speculation, the requirement to do *namaste* entered training curriculums after they had been coined by foreigners who looked for a polite form for "good morning". - Perhaps they had not noticed that they were greeted *namaste* because they were considered more powerful. Certainly, by now *namaste* has become part of the "*bikas*"-culture, the "development culture", a set of values and norms associated with the over 11,000 registered NGOs or the ostentatious four-wheel drives in the narrow streets of Kathmandu. The word *bikas* signifies growth, but in everyday parlance *bikas*

means mostly things and especially commodities that come from outside[61].

Instead of understanding respect as an acknowledgement of another person's priorities and accepting her own form of expression, the development industry has translated the concept into an empty formula awkward and unsuited for the context.

Incomplete introduction: Volunteer L. did not introduce herself or explain adequately what the purpose of her visit was. Out of 22 visitors, 19 spent little time on introducing themselves. This was attributed to the visitors' general insecurity in this situation: they felt awkward to spend too much time in talking about themselves although that would have made it easier for the caregivers to understand their visit. To help the health promoters gain more confidence, we practiced the first meeting in role plays. It became apparent that many found it difficult to explain in simple, non-technical terms why children needed to be weighed and what implications malnutrition had on the development of the child. We were surprised because not only did the volunteers weigh children every month with some enthusiasm, but they also discussed weighing on many occasions during their training. It turned out that they remembered the technicalities, such as the interpretation of the growth line on the "Road-to-health" card, or the fact that growth falters during sickness. That is, they were able to explain what was evident on the Road-to-health"-card. It was harder for them, however, to explain why the family should be concerned that their child's growth line keeps moving upward. From discussions with supervisors of other nutrition projects with a growth monitoring component, it appears that they made similar observations. The implication of a failure to grow is not immediately visible and is thus an abstract concept. Volunteers seem unable to integrate the often not

[61] Pigg (1993)

immediately tangible link between cause and effect inherent in many health concepts.

Giving advice and blaming the victim: Volunteer S. in the above example immediately gave the mother instructions on how she could better look after her children. When the mother didn't respond interestedly, the visitor attributed it to her being lazy and stubborn. We observed this pattern again and again**.** Giving advice had two functions. One, it demonstrated the visitor's knowledge and thus legitimized her role. And two, loading people with advice was a visitor's strategy of dealing with a difficult situation, much like blaming the caregiver for her own situation. The visitors created the illusion of having helped and thus of being in control when they provided the instructions. In the case of blaming the mother for not following the advice, they indicted her for her misery and in this way aggressively rejected the uneasy feelings of fear, hopelessness or sadness triggered by another person's suffering. The following vignette illustrates this process:

> Volunteer R: "I went around 12. The room was so dark, I couldn't see anything. The children were fighting; the mother shouted. There was a mat on the floor but it was almost soaked in water. The child looked very weak and small. He was crying and looked miserable. He is 15 months. She said he eats on his own. I said I think he is hungry, he is crying. She said, no, I just fed them. But I couldn't see any food around. She has this son and two daughters and she is 8 months pregnant. I said: you used to roast peanuts, what do you do now? She said, we don't have anything. We lost this work. I asked: you don't have a job, how are you managing? She said: My husband will find a job. I thought to myself: what to do with such a family? Then I asked what she feeds her child. She said: this and that. I thought she probably doesn't have anything. I didn't know what to say. I couldn't say she should add one more feed. So I said: give dal bhat to your children. Then I said: I will come again. And we made a date".

> After this account, we all felt the futility of the advice she had given out of her own feeling of helplessness. The atmosphere was heavy and sad. But not for long:
>
> Volunteer M: "This family is very stubborn. They pretend. I know them from before. I also told her to go for ante-natal check-up. But she doesn't listen."
>
> Volunteer D: "I also know about this family. When I called them for weighing, the child was laying in the dirt. I said: this child is in the dirt. The mother said to me: your own son is so weak, what are you talking about?"
>
> Volunteer S: "She should continue with what she is feeding."
>
> Facilitator: "But maybe she doesn't have any food."
>
> Volunteer M: "She is buying instant noodles. Instead, she can buy rice. And feed her child."
>
> Volunteer S. "Both husband and wife were working before. They are hard-working people. They lost their jobs. Now, they could do something else, like selling vegetables."

The array and sequence of reactions, from helplessness to aggressive blaming to quickly producing a solution for the family – sell vegetables – was observed in one form or the other in most visiting processes. Sometimes, the health promoter immediately jumped to the last sequence and suggested solutions before having allowed the mother to fully explain herself and reflect her situation. The visitors generally had the need to resolve a situation quickly. It was difficult for them to stay with the feeling that there was no easy solution.

When we discussed the problematic and often counterproductive effect of offering advice too quickly, the visitors insisted that even in the first visit, some suggestions needed to be made because that's what the caregivers expected from a stranger who came to their house purporting to help. Also, the study participants contended, giving advice was part of their normal form of

interaction and could be seen as a way of expressing empathy. We therefore focused our discussions on how to connect suggestions more realistically to the situation of the caregiver, or in other words, what kind of advice was useful and encouraging and when giving instructions was counterproductive and aggressive. By analyzing the possible reasons why a caregiver didn't follow the visitor's suggestions, we tried to deepen the understanding of how poverty, water scarcity, social status or emotional experience influenced the malnutrition of the child. Further, we explained that "giving" was not only a function of telling people what to do or handing out something. One meaning of giving is to take the other person's feelings seriously. To acknowledge and recognize the despair caused by hardship is an important sequence in the long process toward empowerment.

Not hearing emotional information: As mentioned above, health promoters often have not integrated a conceptual framework that explains how psychological factors influence the nutritional status of a child. They thus tend to discard emotional information.

> "Volunteer L: They have a shop and the mother said: the girl eats anything from the shop. Otherwise, she is fed twice a day. Then the mother said: I have so many children. We didn't want this child. I was taking Depo and got pregnant. She looked at the child and complained that the girl was not eating. I said: you should not allow her to eat just like that. And you need to give one more feed. This packaged food from the shop is not good food for the child."

It would have been interesting to know more about the mother's attitude to the child and the family situation in general before forming a hypothesis of why the child was malnourished. But L.'s framework of analysis only contained that inadequate feeding frequency and junk food were unhealthy. She thus didn't listen when the mother said the child was unwanted. She wasn't aware that the mother's attitude to the child can influence the child's eating. - And in

addition, L. may have thought it too difficult to enter a complicated and scary emotional terrain.

For our training sessions, we constructed examples of narratives with several strands of information, technical and emotional, and practiced with the visitors to register the information these strands provided, yet to leave it to the speaker to select which one she wanted to follow up on. As the participants were used to follow clear-cut check-lists, they found it rather difficult to order and combine a variety of information. We thus compiled a list of questions the visitors were asked to keep in mind and practiced how they could follow this mental check-list and still leave the caregiver enough space to influence the course of the conversation.

Teaching skills: Another essential for an effective health promoter is the knowledge of how to help someone understand new information. We observed that home visitors conveyed messages in abbreviated form. For example, they would say: when your child is sick you have to give more fluids – and expected the caregivers to understand and adopt this practice. In the training sessions, volunteers took hours to review their own home health practices and after that to discuss, for example, why a child needed more fluids during bouts of diarrhea. Teaching aids were used to make an abstract concept more plausible such as plastic bags that lost water at the lower end and were filled continuously at the upper end to maintain the same volume, demonstrating what happened to a child with diarrhea. But when the volunteers talked to the families, they forgot how long they had taken to understand a message and conveyed the same information in a sentence or two. We encouraged them to remember their own process of learning such information and to use similar techniques when dealing with their clients. What we learned from this is the necessity of paying enough attention and time on teaching how to teach.

7.4 Socio-cultural identity of visitors

Communication between people is always imbued by the values and norms of their particular social and cultural context. The *generative themes*, i.e., themes that are politically, socially or psychologically relevant in a community thus have to be taken into consideration when working towards improved counseling or communication techniques with project staff. Technical skills alone won't guarantee smooth interactions as they may be undermined by attitudes inherent in the social order. In the examples we discussed above, the communication was not only shaped by limited skills but also by the strictly hierarchical social organization and the identity of women in Nepal.

7.4.1 Hierarchy

Hierarchy between people is defined mainly by the caste system and by the economic status.

The dominant cultural matrix within which people in Nepal relate to each other is the hierarchical order of the **caste system** (see chapter 3). Members of the higher castes often find it difficult not to talk down on members of lower groups as a matter of right or course. This cultural pattern can undermine efforts to encourage a respectful and empathetic attitude deemed necessary for successful health promotion. When a community facilitator expressed her relief of visiting a family of her own group, she spoke for many: "I had no problems, she is also a Brahmin, I felt immediately at ease." In the culturally diverse urban environment of Kathmandu it was more common that visitor and caregiver were of different groups. The difficulties arising from such a constellation can be illustrated with the narrative of volunteer B.'s first visit to a renter family in her neighbourhood. Volunteer B. embodies most attributes of

being situated high in the hierarchy. She is a Brahmin and her family owns property in the area.

> "The mother is called Maya Tamang. She lives in a very damp, small, dark room. It's very cold inside, no windows. And really, she keeps chicken in that room! I said to her I work for women and children and that's why I came. Your daughter is underweight. I came to visit you because your child is small. The mother said she breastfed for 3 months, after that she couldn't. All the time, the child is sick, she said. I asked how often she was feeding her? She said: I give her 3 times. I said, you should add 2 more times of the same food. Just keep the food and give it in between. I thought maybe they have many family members, that's why the child is underweight. But they are only 4 of them… It was so dirty, there was no place to sit down. Then the chickens! It was so difficult for me to pass the time. She is not a bad person. She recently arrived. I said she should keep the child clean and the room also. In the village, they are very busy but here, they are not busy. So, she can keep the child clean. In the end I said, I will come again – meanwhile you feed 5 times."

What is most striking about this interaction is the unease the visitor feels. She can't cope with the environment she finds herself in. While we can imagine how she felt and acted, we cannot picture the mother and the child. The volunteer was so preoccupied with her own feelings that she could not "see" or "meet" the mother. We often observed in volunteers that they were too preoccupied with their own fears or indignant reactions to the environment so that they could not really relate to the mother they came to meet.

After mentioning her name, Vounteer B. never openly referred to the mother's ethnic group, which is considered low in the Nepali caste totem. It is apparent though that she shares the high-caste prejudiced view of Tamang as having many children and being dirty. She immediately suspected that the child was underweight because the birth spacing was too short. She described the "dirty" environment so graphically that this feature eclipsed everything else. The

chicken in the house were particularly offensive to her – chicken inside the room are not only an attribute of the poor and uneducated recent arrivals from the village, but chicken are also often related closely to Tamang who use these animals for sacrifice and for many of their rituals, while more orthodox Brahmins don't eat or rear chicken.

The hierarchy between Volunteer B. and Maya Tamang led the visitor to feel awkward and triggered an unsympathetic behaviour. Her prejudice and fear led her to make quick assumptions about the causes of malnutrition and prevented her from actually meeting the mother. She had hardly introduced herself when she started to give advice on controlling what was in effect her own unease and helplessness. Her interventions had nothing to do with the family's concerns or priorities.

The superiority some visitors felt was not only based on their higher caste but was sometimes connected to their better **economic status**. Volunteer B. who visited Maya Tamang was a landlady. In our study group in ward 35, four of seven participants were landladies and three of them had been assigned to visit one of their own renters.

Among all of Sagun's volunteers, about 25% are house owners. It seemed that Sagun's staff had selected more and more landladies as volunteers because unlike many renters, who shift living quarters frequently without leaving contact details, they are stable. But in our research we quickly realized that of all the factors governing relations between the volunteer and the family, the landlady-renter hierarchy is the most likely to prevent a relationship of trust. The visitors told us many anecdotes of how landladies affect the living situation, including the privacy, of their renters; and how renters don't pay their rent or borrow money from their landlords. Because of this loaded

relationship, one of the visitors, a daughter of a landlord, felt awkward to visit the renter family. “I felt not very comfortabel, I felt I would have to ask her questions she may not want to answer.” As a result, the young visitor restricted the conversation to food and was reluctant to explore other areas. Another landlady didn’t feel like visiting and asked the mother to come to her place, thus demonstrating who was in charge here. A third volunteer gathered information that the mother didn’t want to give about her absent husband from her other renters. For this research we asked the landladies to change the families and visit someone who was not renting their property. Sagun is now discussing how to organize the work in the wards differently so that house owners will not have to visit their own tenants.

While the economic gap between the mothers and the volunteers may be partly addressed by a more conscious selection of volunteers, the dynamics between members of differently ranked social groups cannot be avoided through selection. It is an integral part of the social set-up in the given context. We observed that of the 22 visitors in our sample, all but 3 expressed difficulties in dealing with the many manifestations of distinction between themselves and the families visited. Very rarely though did the visitors openly refer to caste or ethnic group. Their attitude was manifest in their actions rather than their explanations. This is partly to be explained by our own critical view of caste consciousness and hierarchical attitudes – something the volunteers very quickly surmised. As we stood higher in the hierarchy, they were cautious about expressing their opinions, for everybody tries to avoid disapproval by the “higher authorities”.

Everybody in Nepal lives under the same paradigm and it is simply not possible to escape caste consciousness and hierarchical attitudes in this society. Just declaring it as bad is obviously not a solution. Change will come only if

difficulties with difference and hierarchy are continuously addressed and discussed. How personal interaction and the discussions about it will bring about change can be seen in the example of community facilitator Ashmina Nepali. She is considered "untouchable" (her story has been told in chapter 2: "Ramifications of an intercaste marriage"). For this study, Ashmina had to visit a family who belonged to a slightly higher caste. During her 8th meeting with the mother Nirmala Shahi, Ashmina talked about herself and revealed that she could not visit her maternal home:

> "The mother asked me why and I said: intercaste marriage. She asked me which caste and I said I was a Shrestha but had married a sweeper. She looked at me very shocked and I felt guilty because I was in her kitchen….She stared at me. I felt she will say something, ask me to leave. But after a while she said: I will prepare tea for my father-in-law and my brothers-in-law. Would you like to have some? I said I wanted to go and she came with me to the door. On the way, she asked whether I wanted to meet her father-in-law. I said, no not today, I will go now."
>
> Ashmina had never before reported that she talked much about herself to Nirmala Shahi and now, when she sat for the first time in the kitchen, the place most tightly guarded from pollution in most Hindu households, she disclosed her caste – which apparently she had never mentioned to the mother who simply called her didi (older sister). Ashmina may have unconsciously wanted to test the mother's reaction, to see if she would be acceptable as well as to contest the traditional hierarchy.
>
> The mother's reaction took an unexpected turn: she could have cut off the relationship with Ashmina but she didn't. Instead she offered to introduce her to her father-in-law, the authority in the house. After that visit, Ashmina was nervous to go back. Would Nirmala change her mind, would the family reject her next time? For more than two weeks she found reasons not to visit. But when she eventually returned, she found that they had accepted her. The relationship they had developed over the previous two months was more important than keeping to the caste rules.

Over the last two years, many members of Sagun had similar experiences because the project approach encourages, even requires, that visitors cut through cultural boundaries and relate to the person behind the sociological category.

7.4.2 Position of women in family and community

The home visitors of the Urban Nutrition Project are women. They involve all family members in their discussions about the child, often however it is the mother with whom they mainly interact. She is considered to be primarily responsible for the children and, often, she is the one who stays at home to care for them. It would create an unacceptable social situation if an unrelated man came to the house to talk to the mother. And obviously, women find it easier to discuss private matters with a woman. It is thus a choice of the project to select female health promoters.

As outlined in Chapter 5, the position that women have in the family and community heavily influences the nutritional status of the child. The key issues in the relation between men and women, the various roles women assume and the expectations they have to fulfill are often discussed in Sagun's trainings for volunteers and during the case review sessions. Apart from that, there is discussion of the strategies in working with family members opposing change in favour of mothers. In such projects, though, not enough consideration is given to the implications of female health promoters or home visitors supporting female caregivers.

Firstly, the caregiver's story may trigger strong emotions in the home visitor who, as a woman, may experience comparable conditions in her own life. It may help her identify with the caregiver, forging a feeling of solidarity

between them, and make her determined to help her resolve her situation. But it can also create an emotional entanglement so that the relationship between the caregiver and the visitor turns murky.

Secondly, the health promoter shares her society's values and has similar expectations as to how a decent woman and mother should act. If the caregiver goes against such ideals, the home visitor may withdraw support or even react aggressively to someone who dares to break the rules.

The dynamics between the visitor Devi and the mother Sushila reflect these key issues:

> During Devi's first visit, Sushila, mother of a 31-month-old girl, described how she lost her husband in an accident when her child was only 45 days. Left with no income, she sold vegetables in the streets. Whereas she had been a middle-class housewife before, she now struggled with desperate working and living conditions. Devi listened to the mother with interest and involvement. "When she talked I felt very sad. She is just 24 years old and a nice person and became a widow so early." After a while, however, Devi changed the subject and started to talk about feeding of the child. "I made a time table with her for feeding. I told her how to mix the three types of food." The mother said "yes, yes, I will try" but, Devi noticed that "she looked depressed, frustrated. After her husband died, maybe many people came to tell her what to do." The visitor realized she had done the same and felt bad about it. But she found it emotionally difficult to keep listening to the other woman's hardship.
>
> During the next visit, Sushila told Devi how shocked she had been when she realized the change in her husband's colleagues after his death. While they were respectful as long as she was his wife, they made sexually ambiguous comments as soon as she was a widow. Sushila also told Devi that men harassed her while she sat on the pavement to sell vegetables. Then Sushila cried. Devi felt very bad. After a while she switched the conversation to the need to boil water for drinking. Later, she commented: "I diverted, I talked about something else. I talked about the water, the child, the food and then I

closed for the day." Devi explained that listening to the mother had been very hard for her.

In the following visits, Sushila talked about her desperate economic situation and described her difficult life as a vendor in great detail. Each time Devi tried to change the subject to the child's nutrition and health, the mother seemed disinterested: "She talks very spontaneously about her life as a vendor but when I want to talk about feeding she only gives very short answers," Devi reported.

In her 9th visit, Devi was chatting with Sushila, her sister and the little girl when two friends of Sushila dropped by to take her along to a fair. Sushila's sister reacted angrily to Sushila's wish to go out: Why should she enjoy herself while her child was sick and needed attention? The conflict between Sushila and her sister made Devi uneasy. She switched the conversation to the child's health but the mother didn't show much interest. Devi told her that as the girl was unwell, she had to feed her small quantities more often. Sushila replied that the girl didn't eat anything. "She said it as though she was pleased about it," Devi said, angry with Sushila's seeming lack of interest in the child. Now, she observed for the first time that the child looked very passive, very gloomy and sad while the mother looked fat, bright and active. Whereas Devi had once identified with the mother, she now identified with the child.

During the following visits, Devi usually asked about the child's eating and the mother responded disinterestedly. Sushila closed herself off more and more and the visits became increasingly meaningless. The child's nutritional status hardly improved.

In the beginning, Devi identified strongly with Sushila, who had to cope with great hardship and was courageous to stand up for herself. The only way Devi could cope with the strong emotions Sushila's narrative triggered in her, was to divert the discussion to technical aspects of child care. Devi was aware of this dynamic. But at the moment itself, she was unable to keep the mother's emotions separate from herself. This is understandable as she is not a professional counselor and was not prepared for what came. And as we showed in chapter 5, the cultural framework is so hard on women that in one way or

the other each of them has her own difficult experience to come to terms with and may, when confronted with another woman's suffering, feel directly touched by the story she is told.

The crucial *key situation* in this process, however, was Devi's switch of identification from mother to child when she realized that Sushila was not merely a struggling single mother, but also a young woman who wished to enjoy herself in the company of friends. It is culturally not acceptable that a widow and mother is also a woman with her own desires and aspirations. The implications of breaking such taboos, of being free from moral demands, seemed too dangerous for Devi to respond supportively. Sushila's refusal to accept the restrictions of motherhood and widowhood provoked anxiety and anger, not only in Devi, but also in us, her supervisors. We were thus not able to help her to interpret what was happening. In retrospect we recognize that it is exactly this bias against female self-realization which we have to understand and deal with if we want to truly support the empowerment of mothers.

7.5 Conclusions

Successful health promotion implies the **empowerment** of caregivers to make changes that help their children grow. The health promoter thus has to act as a facilitator of empowerment. This involves the building of a relationship of trust with the family; it requires comprehending the complexity of the situation and patiently supporting caregivers to take action rather than dishing out instructions at the word go. Many participants of our action research had difficulties in successfully applying this concept. We located the obstacles mainly in three areas that invariably overlap and reinforce each other:

The **professional identity of health personnel** entails a pronouncedly hierarchical relation to the patient. Traditionally, they give drugs and instructions without getting really involved with the clients. When health promoters were asked to simply listen to caregivers first, they often felt uneasy, because without "giving something" they seemed bereft of their legitimacy. A further obstacle in a psychosocial, empowering approach to nutrition is the vertical nature of conventional health training and practice . A particularly complex condition like malnutrition, however, requires the ability to consider social, economic and psychological factors in addition to medical and dietary facts. Neither their training nor the understanding of their role prepares health staff to deal with the multifaceted conditions they find in the families of malnourished children.

The capacity to facilitate empowerment is not only related to the professional role of the visitor, it is also connected to the ability to communicate well. We identified a number of key issues that require special attention when working to improve **communication skills** of health promoters: The visitors didn't have the means to satisfactorily explain to the family why they came to visit and why it was important to talk about the weight of the child. Further, the health promoters often felt unable to bear with the desperate situation of a family. The resulting feeling of helplessness led them to either overwhelm the caregiver with advice or to blame her for her own misery. Visitors found it difficult to stay with the feeling that there was no easy solution. But a crucial part of a successful empowerment process is precisely possessing such a capacity; that is, acknowledging the difficulty of a situation and recognizing the emotions connected to it. Often, mothers were quite open about their difficulties and their attitude to the child; however, visitors tended to discard emotional information. It didn't fit into their predominantly medical framework of analysis and it sometimes seemed scary to enter the terrain of

complicated family dynamics. A last challenge in the communication process, we realized, was how to convey health information successfully. Visitors tended to convey a message in a sentence although they themselves had spent hours in their training to understand the same concept.

While we worked with the health promoters to improve their skills, we realized the impact of their **socio-cultural identity** on the communication process. The ability to communicate well was adversely affected by the hierarchical relationship between members of different castes or economic groups. The communication of female health promoters with mothers was also strongly influenced by their identification with the suffering of the other woman or by their moral judgement if she didn't conform to the prevalent norms of womanhood and motherhood. Both generative themes – hierarchy and gender – informed every interaction between visitors and mothers and often undermined efforts to establish a good relationship with the caregivers.

We concluded that if we really believed in the empowerment of caregivers and health promoters, it was not enough to conduct a few training sessions in communication skills. Instead, we had to patiently and continually identify and address the many layers of obstacles to build more equal relationships in the community. The transformation we observed in many of the participants of this action research showed that a long process of small steps will allow health promoters to experience that a different way of interacting is possible and enriching.

Chapter 8 – 10 Recommendations for the psychosocial approach in nutrition

Focus on the caregiver

We often think of caregivers as the means to improving the health of children. We assume that if only they could acquire more knowledge and skills, the child would quickly gain weight. But the empirical reality is vastly different. Almost all the caregivers we met in the course of this action research were entangled in difficult family dynamics and/or in a desperate economic situation. Most of the mothers had ambivalent feelings toward their malnourished children. The first preoccupation of a health worker intent on improving the nutrition of the child must be directed at the psychosocial situation of the caregivers.

Define "psychosocial" as a method

For the Urban Nutrition Project and for this action research, we have defined "psychosocial" not as a specific activity to be added onto a nutrition project but as a working method. The psychosocial approach is characterized by process-orientation and by an overriding interest in the individual caregivers and children, for their autobiographic experience and their socio-economic situation. The psychosocial method does not separate the individual agency and the social conditions but understands and accepts their interdependence and works with that. For example, a mother's hesitation in bringing her child for medical treatment to the health facility may at once represent her ambivalence to the child and her wish to avoid the unfriendly and authoritarian nurses at the clinic. In a psychosocial approach, this mother will be helped to reflect on her relationship to the child and to understand the importance of medical treatment. The problem of the health staff's attitude will also be

addressed, for example, by the capacity building of health workers or by encouraging community members to demand better services.

Define the health promoter as a facilitator of empowerment

Health promotion is often misunderstood as conveying health messages. But in our experience, families with malnourished children were mostly not able or willing to translate general health information into a change of behaviour. In our psychosocial approach, we work with the understanding that people are capable of integrating knowledge only if it is related to their personal situation and helps them gain better control of their own lives. Health promotion must thus set out the objective of empowering families with malnourished children toward a course of action that leads to an improved situation. To successfully work with caregivers towards this goal, the health promoter must be capable of listening, building trust, and supporting people to make changes rather than giving them something or telling them what to do. The facilitation of empowerment therefore requires three basic attitudes in health promoters[62]:

***Respect*:** Caregivers of malnourished children are often beset by many worries and concerns – about their economic situation, their child's health, their family situation or their social marginalization. A health promoter who comes to advise them on what they should do to solve their child's problem may only further victimize the family members as telling people what to do is to demonstrate superiority. Instead, they should show respect, which entails taking an interest in the specific history, situation and priorities of a person. This sometimes implies that recognizing the malnutrition of the child is not the most pressing issue to be addressed.

***Comprehension*:** The health promoter should be capable of understanding nutrition holistically. In addition to medical and nutritional

facts, economic, social and psychological factors have to be considered when working with families of malnourished children.

***Relationship*:** Most important, the health promoter should be ready to enter a real relationship with the caregivers because a close relationship with another human being is the basis for learning and developing.

The professional role of a health worker in Nepal does not favour such attitudes. Generally, health training prepares professionals and para-professionals for a purely bio-medical understanding of illness and for a hierarchical manner of dealing with the patient. We must thus invest considerable effort into training and supporting staff and volunteers if they are to assume a different role.

Broaden the training of health promoters

The volunteers that participated in this study were trained in basic health information in 8 half-day sessions spread over 8 weeks. The curriculum focused on care practices related to the Minimum Package of nutrition interventions[63] and added extra sessions to deal with psychosocial factors such as family dynamics and the impact of abuse on children.

We suggest to spread the training period over a longer period since it has the advantage of allowing a solid relationship of trust to form between trainers and participants and among participants, thus enhancing the learning process. In this process, the volunteers have to learn the basic content of the Minimum Package of nutrition interventions as they did in the training for volunteers. We would however recommend not adding extra sessions on "psychosocial" issues

[62] Becker, 2001/2

[63] Exclusive breastfeeding until about 6 months, appropriate complementary feeding starting at about 6 months and continuing until 24 months, adequate Vitamin A intake for women and young children, appropriate home health care, iron/folate tablets taken by all pregnant women and regular use of iodized salt by all families.

but to incorporate the psychosocial logic into every session. If the topic is diarrhea, for example, participants will discuss the impact of hygiene as well as the effect of anxiety or stress on the digestive system. This method will help participants to integrate the psychosocial way of thinking, especially if all the inputs are drawn from the analysis of the participants' personal experience with the care of their children. Information concerning the psychological needs of children and the implications of abuse on children, for example, however, are important and should be kept in the curriculum.

Building a relationship with caregivers and facilitating their empowerment requires specific skills. The key issues of such communication can be practiced through role playing:

- the importance and significance of the first visit and the techniques required to make it effective
- the often adverse impact of giving advice too early
- the ability to notice the different strands of information in the narrative of caregivers and to hear not only the technical and medical but also the social and emotional information
- skills to explain health information to caregivers.

In training health promoters, the skills required to facilitate empowerment should be given the same importance as the content of health messages. Teaching messages make no sense unless the health workers know how to help families understand and apply them.

We realized that it is often hard for trainees to apply the lessons of a workshop to the practical situation in the field. We thus suggest keeping the training phase short and place more emphasis on the learning process that will take place once the work begins.

Institutionalize regular case review sessions

Sagun meets the volunteers every month for a review of their work. We recommend strengthening the value of these discussions by defining them as a continuation of the learning process initiated in the training workshops. Once the health promoters start working, they can describe how they interact with caregivers. This makes it easier to take up issues connected to the establishment and development of the relationship between home visitor and caregiver. Key issues here are:

- strategies of home visitors or health promoters to deal with their own helplessness when confronted by a difficult situation (blaming the victim, offering solutions too quickly)
- hierarchical attitudes toward people belonging to lower ranked social or economic groups
- the effects the story of the caregiver can have on the visitor

Discussing concrete experience with families can deepen the health promoters' understanding of communication processes. At the same time, the analysis of family situations can also help the visitors to gain skills in interpreting the causes for malnutrition. Such on-the-job training may seem like an unnecessary investment, but it is not so since the empowerment of volunteers follows the same principles as the empowerment of families: They need exposure to new ideas and the opportunity to reflect on their experience; they need emotional support when exploring a different attitude and behaviour.

Make Gender a focal point for reflection

In Nepal, mothers are considered primarily responsible for child care. It is her position in the family and her community's values and beliefs about womanhood that shape a mother's relationship to her children and influence

the dynamics and support systems within the family. All health promoters in Sagun's Urban Nutrition Project are women. They belong to the same value system and often have similar experiences as the mothers they visit. This can significantly shape their ability to build a relationship with the caregiver. It can bring about a feeling of solidarity in the health promoter, who then wants to support another person experiencing similar difficulties. But it can also trigger fear or shame and a need to distance oneself because the emotions aroused are too intense. If a caregiver goes against society's strict rules and sets out to realize her own aspirations, the visitor that suppresses similar wishes in order to conform to her family's expectations may react aggressively.

It is important for health promoters to discuss gender relations and the implications of the gendered matrix of values and beliefs for the nutritional status of the children they work with, for the sake of the relationship they form with the caregivers and for their own lives. Only by reflecting on such dynamics and by analyzing the underlying structure of gender relations can the female visitor slowly integrate a different attitude to the caregiver and to herself.

Address generative themes at the community level

The position of a woman in her family and community determines what support networks she can rely on. In Kathmandu, women have few opportunities to meet people outside of their family and relatives. The exposure to new ideas and the friendships gained through Sagun's training, as well as the opportunity of assuming a public role, were cited by volunteers as their main motivating factors for participating in the project. Sagun has thus been able to connect these interests of women to their need for external support in caring for their children. Besides providing such support to individual families, volunteers have also established child care centres. These centres are managed jointly by volunteers and parents, thus building additional networks.

Based on these achievements, we suggest that Sagun creates similar networks around other generative themes, in particular the key issue of water scarcity. Such social mobilization may lead women to interpret unsuccessful efforts to gather enough water as a problem to be taken up with the Nepal Water Supply Corporation rather than as a failure to be blamed on individual mothers of malnourished children.

A project with a psychosocial approach to malnutrition should interpret and address generative themes – these being gender, water scarcity, poverty and the underutilization of health facilities in Kathmandu - on an individual and a community level. The psychosocial approach does not separate the private and the political but looks at the interface of the two spheres.

Define the setting for home visits

For this research we did not limit the number of home visits per family; neither did we formulate clear indicators as to when a visiting process can be considered to have reached its goal. In fact, one of the intentions of this research was to gain greater clarity on how we can define the setting for a meaningful home visiting process.

Initially, we were convinced that continuous weight gain over two months would be a sufficient indicator that caregivers had made the necessary changes for the child to improve. We subsequently found that a child's weight could show a temporary improvement for many reasons, such as, for instance, the positive impact on the caregiver by the fact that someone came to help her cope better. But such weight gains were generally unsustainable if the child's eating or health problems were caused by complicated factors such as poverty, tensions in the family, or the attitude of parents to the child.

We realized in our research process that it takes time for caregivers to open up to the visitors by talking about worries that are often connected to the child´s malnutrition. It takes even longer for families to actually change. Change is not a unilinear process and progress is often interrupted by stagnation or backlashes.

Although it would be ideal if the health promoter could be left to assess whether the change observed is sufficient and whether it is time to close the visiting process, we understand that volunteers in particular may find it difficult to act without guidelines. We would thus recommend visits to extend over two months for a total 6 times, though 8 is better. After this period, the visitor, perhaps with the help of peers or the support of a supervisor, must assess whether the child's situation has improved enough for the process to be closed or whether interaction with the family should be continued. Indicators for this assessment are:

- Weight gain over two months. The child should have gained weight. If the child has lost weight or the weight has remained unchanged, the whole situation must be reassessed, possibly with the help of a more experienced staff.
- Change in care practices achieved. The visitor has to assess what changes have been made. If possible, this assessment should be based on observation and not merely on the report of the caregiver.
- Social empowerment of the caregiver. Have changes been made in those areas that contribute to the malnutrition of the child? For example, if the caregiver said that the child doesn´t eat after fights between his parents, has there been an attempt to address the reasons for these fights or to work towards a different form of negotiations between the parents?

If the visitor determines that there has been a positive development in at least two of these indicators, the visiting process can safely be concluded. If the outcome is unclear, a different form of interaction can be tried; for example, the visiting process can be interrupted for a certain period and the visitor can reassess the situation after the following weighing session.

A change of setting should always be discussed with the caregiver. It is vital that the closure of the visiting process be a conscious decision by visitor and caregiver after a common assessment of the achievements. The relationship of trust that has evolved between health promoter and family members requires an adequately prepared and discussed separation. All efforts should be taken to ensure that the caregivers are not disappointed and angry at having been left behind. A closure that has not been properly reflected on may undermine all that has been achieved in the process.

Create conditions for staff empowerment

In the hierarchical social set-up of most societies, certainly including Nepal, a non-authoritarian, participatory working style does not come easily to health workers. If people learn new ways of thinking and relating only during training, with these workshops remaining islands in an otherwise highly hierarchical environment, we cannot expect staff to go out into the community to facilitate empowerment. Field workers must have the opportunity to become familiar with and to practice participatory decision making and critical thinking. The best place for that to happen is the organization to which they belong. Sagun's experience with a flat hierarchy and a rather flexible work organization has been very positive. The staff are involved in training, home visiting and in supervising volunteers. Even those staff members that write reports facilitate trainings. Being involved in the whole spectrum of activities

enables staff to integrate their experiences and to better understand the logic of the whole project. This goes a long way in creating the preconditions for participatory decision making.

Organizational development advisors often talk about the necessity of focusing on the potential of staff. We completely support this principle and believe it to be the ground rule for effective working. But we recommend working also towards an organizational culture that favours an uninhibited attitude toward weakness. It is the fear of making mistakes that poses the biggest obstacle in developing a new way of working.

Use action research as a tool to introduce the psychosocial method

As we have shown in this report, the challenges of introducing a psychosocial approach in the context of Kathmandu are considerable. We have however been gratified by the change in attitude and motivation achieved by the participants of this study in a short period of four months. Helped by regular case reviews and a few training inputs, we were able to initiate a broadened understanding of malnutrition and a greater respect toward caregivers. Staff and volunteers realized that they could achieve something and found that their interactions with the families were rewarding when they committed themselves to getting involved and acquired the skills to do so.

Action research is an ideal tool for introducing the psychosocial method. Participants come to experience that it is possible and often rewarding to bear with the feeling of not knowing and not understanding. In the process of gaining greater clarity, participants endure the implications of their own reluctance in relating to the caregivers when working with them and subsequently then the difference when they are able to change their attitude.

The solutions and answers the team or individual staff members arrive at in the process are absorbed in a much deeper way than any readymade instructions presented in a workshop. Action research is in fact just what health promoters should be engaged in while dealing with caregivers of malnourished children: facilitating a process that leads to greater clarity about a given situation while increasing the agency to change it.

References

Bennett, L. (2002). *Dangerous Wives and Sacred Sisters. Social and Symbolic Roles of High-Caste Women in Nepal.* New York: Columbia University Press and Kathmandu: Mandala Book Point.

Bennett, L. (1976). Sex and Motherhood among the Brahmins and Chhettris of East-Central Nepal. *Contributions to Nepalese Studies* (June), no.3. Special Issue on Anthropology, Health, and Development. Kirtipur: Institute of Nepal and Asian Studies, Tribhuvan University.

Becker, D. (2001a). Fuenf Thesen zur psychosozialen Arbeit in: *Die Gewalt ueberleben. Psychosoziale Arbeit im Kontext von Krieg, Diktatur und Armut*. Medico Report 23. Frankfurt am Main: Medico International.

Becker, D. (2001b). Dealing with the Consequences of Violence in Trauma Work. In: Austin M, Fischer M. and N. Ropers, *Berghof Handbook for Conflict Transformation*, Berlin: Berghof Research Center for Constructive Conflict Management.

Bista, D.B. (1991). *Fatalism and Development – Nepal's Struggle for Modernization.* Calcutta: Orient Longman.

Bossyns, P. (2001). Under-Five Clinic: An Obligation to Change the Paradigm in: Patrick Kolsteren, Tom Hoeree and Armando Perez-Cueto (eds). *Promoting Growth and Development of Under Fives*. Proceedings of the International Colloquium. Antwerp 28-30 November 2001.

Bouville, J –F. (1993). *Aspects relationnels de la malnutrition en milieu urbain africain.* Cahiers Sante 1993; 3:433-440.

Cameron, M.M. (1998). *On the Edge of the Auspicious. Gender and Caste in Nepal.*
Urbana and Chicago: University of Illinois Press.

Central Bureau of Statistics (2003). *Gender Disaggregated Indicators, Nepal*. Kathmandu: National Planning Commission.

Central Bureau of Statistics (2001). *National Population Census 2001*. Kathmandu.

Chapagain, K. (2003). *Widow marriage: A youth sets an example*. Kathmandu Post 31.5.2003.

Dixon S. D., Levine R. A. and T.B. Brazelton (1982). Malnutrition: A Closer Look at the Problem in an East African Village. In: *Dev Med Child Neurol*. 24:670-685.

Engle, P. L., Bentley, M. and Pelto, G. (2000). *The role of care in nutrition programs: Current research and a research agenda.* Proceedings of the Brit. Nutr. Society, 59:25-35.

Engle, P.L. and L. Lhotska (1999). The role of care in programmatic actions for nutrition: Designing programmes involving care. Food and Nutrition Bulletin, 20:121-135.

Engle, P.L. (1997). *The Care Initiative – Assessment, Analysis and Action to Improve Care for Nutrition.* New York: UNICEF.

Engle, P.L. and H. N. Ricciuti (1995). Psychosocial aspects of care and nutrition. In: *Food and Nutrition Bulletin*, vo.16, no. 4.

Freire, P. (1970). *Pedagogy of the Oppressed*. New York: Continuum

Gellner, D. (2001). *The Anthropology of Buddhism & Hinduism – Weberian Themes.* Oxford/New York: Oxford University Press.

Gellner, D. and D. Quigley (eds) (1995). *Contested Hierarchies – A Collaborative Ethnography of Caste in the Kathmandu Valley, Nepal.* Oxford/New York: Clarendon Press Oxford.

Geertz, A.W. (2002). Synoptic characterization of Clifford Geertz's essay: "Thick Description: Toward an Interpretative Theory of Culture", http://www.teo.au.dk/html/geertz/Classic6a.htm).

Goodall, J. (1979). *Malnutrition and the family: deprivation in kwashiorkor*. Proc.Nutr.Soc. (1979), 38: 17-27.

Goodfriend, M. (1999). *The importance of psychosocial paediatrics in the developing world.* In: Tropical Doctor 1999, 29:90-93.

Gurung, H. (2003). "Trident and Thunderbolt – Culture Dynamics in Nepalese Politics." *The Mahesh Chandra Regmi Lecture.* Kathmandu: Conference on The Agenda of Transformation: Inclusion in Nepalese Democracy.

Hoefer A. (1979). *The Caste Hierarchy and the State of Nepal. A Study of the Muluki Ain of 1854*. Innsbruck: Universitaetsverlag Wagner.

Hutton, (2002). *Equity and Access in the Health Sector of Eastern Europe and Central Asia: A brief review of literature*. SDC and Swiss Tropical Institute, Bern and SDC-Health: Access to health services, www.sdc-health.ch/priorities_in_health/

Ivey, A. E. and M.B. Ivey (1998). Intentional Interviewing & counseling. Facilitating Client Development in a Multicultural Society. Fourth Edition. San Francisco.

Joshi, A. R. (2001). Educated Mothers, Extended Households and Child Health, in: *Studies in Nepali History and Society*, Vol. 6 No 1 June 2001, Kathmandu.

Kakar, S. (1997). *The Inner World. A Psycho-analytic Study of Childhood and Society in India.* Calcutta (Oxford India Paperbacks).

Kristvik, E. (1999). *Drums and Syringes.* Kathmandu: Bibliotheca Himalayica.

Lumanti (2001). *Asian Cities in the 21 Century: Contemporary Approaches to Municipal Mangement*. Vol V Fighting Urban Poverty. Manila: ADB.

Ministry of Health (1998). Nepal Micronutrient Suvey. Kathmandu: MoH/Division of Child Health, New Era, Micronutrient Initiative, WHO.

Ministry of Health (2001).Nepal Demographic and Health Survey 2001. Kathmandu: MoH/Family Health Division, New Era, ORC Macro Calverton.

Olds, D. and H. Kitzman (1993). Review of Research on home visiting for pregnant women and parents of young children. *The Future of Children*, Vol. 3/3.

Pandey, B. (2002). *Women's Property Right Movement and Achievement of the 11th Amendment of Civil Code*. www.nepaldemocracy.org.

Pigg, S. L. (1993). *Unintended Consequences: The Ideological Impact of Development in Nepal.* South Asia Bulletin, Vol XIII Nos. 1&2: 45-58

Prevel-Martin, Y. (2002). *"Soins" et nutrition publique.* In: Cahiers Sante, 2002; 12:86-93.

Quigley, D. (1995). Conclusion: Caste Organization and the Ancient City. In: Gellner, D. and D. Quigley (eds), *Contested Hierarchies – A Collaborative Ethnography of Caste in the Kathmandu Valley, Nepal.* Oxford/New York: Clarendon Press Oxford: 298-327.

Ramalingaswami V., U. Jonsson and J. Rohde, 'The Asian Enigma', *The Progress of Nations 1996* (New York: UNICEF, 1996).

Rauchfleisch, U. (1996). *Menschen in psychosozialer Not. Beratung. Betreuung. Psychotherapie*. Goettingen: Sammlung Vandenhoeck.

Sagun, NZFHRC and University of Guelph (2001). *Final Report. Participatory Action Research on Urban Ecosystem Health in Kathmandu Inner City Neighbourhoods*. Kathmandu.

Stimmer, F. (2000). Lexikon der Sozialpaedagogik und der Sozialarbeit. Muenchen: Oldenbourg.30

Tamang, S. (2002). "The politics of 'developing Nepali women'" in K. Dixit and S. Ramachandaran (eds), *State of Nepal*. Kathmandu: Himal.

Thapa, M. (2003). Girls in the war. Himal, 6 June 2003. Kathmandu.

Terre des hommes /Sagun (2001). *Knowledge, Attitude and Practice in relation to nutrition of pregnant women and children in Ward 19 and 20 of Kathmandu Metropolitan City.* Kathmandu.

UNICEF (2001a). *Training Handbook on Psychosocial Counselling for Children in Especially Difficult Circumstances*. Second Edition. Kathmandu.

UNICEF, (2001b). *A South Asia Orientation to ECCD*. Kathmandu: UNICEF Regional Office for South Asia.

UNICEF (1990). *Strategy for improved nutrition ofchildren and women in developing countries*. Unicef Policy Review, OQEH. New York: Unicef.

Watzlawick P., J.H. Beavin and Don D. Jackson (2000). *Menschliche Kommunikation. Formen, Stoerungen, Paradoxien.* 10. unveraenderte Auflage. Bern: Hans Huber.

WHO (1999). *A Critical Link. Interventions for physical growth and psychological development. A review*. Geneva: WHO.

WHO (1998). Health Promotion Glossary. Geneva.

Zimmer, J. (2000). Das kleine Handbuch zum Situationsansatz. Weinheim und Basel: Beltz.

Zimmer, J. (1976). Ein Bezugsrahmen vorschulischer Entwicklung. In: Zimmer, J (eds). Curriculumsentwicklung im Vorschulbereich. 2.Auflage. Muenchen.