Qualitative Analysis of Socio-Cultural Factors Influencing Mother and Child Nutrition in Nepal.

INTRODUCTION

The Mother Child Wellbeing Partnership Program (MCWPP), implemented by CARE,iDE and MAP in five districts of Nepal—Dailekh, Surkhet, Banke, Kailali, and Rautahat—aims to improve maternal and child health by addressing gender relations and social norms influencing nutrition. This qualitative study, conducted under MCWPP, explores factors affecting the nutritional status of pregnant and lactating women, focusing on the critical first 1,000 days and marginalized groups. A CARE Nepal study highlighted how cultural norms, including caste, education, and economic status, influence dietary habits, while harmful practices driven by gender bias persist. This qualitative study employs a thematic approach to identify nutritional malpractices, understand the impact of social and cultural norms, and provide actionable recommendations. Data collection involved Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) with diverse stakeholders, including community leaders, health workers, and beneficiaries.

Center for Research on Education Health and Social Science (CREHSS) carried out this study for CARE Nepal from November, 2024 to December 2024.

Research Methodology

This study employed a purely qualitative approach for data collection, conducted across

10 Selected Municipalities and Rural Municipalities selected in five program districts

15 A total of FGDs conducted

25 Key Informant Interviews (KIIs) held with diverse stakeholders,

including community leaders, health workers, and beneficiaries, using tailored FGD and KII guidelines designed to meet the study's objectives.

Stakeholders were purposively selected with the assistance of the local implementing partner organization. All interviews and discussions were audio-recorded with participants' consent, and the collected data were transcribed and translated into English as needed.
A thematic analysis was conducted based on the research objectives. To further support the findings, data related to social norms were extracted from a separate quantitative study conducted in the same districts with women aged 15 to 49 years.

KEY FINDINGS

The study findings from both KIIs and FGDs are analyzed in various themes derived from the objectives of the study.

Nutritional Malpractices within Communities

Cultural beliefs significantly influence nutritional practices during pregnancy and postpartum, sometimes leading to harmful malpractices that affect maternal and neonatal health across the study districts. A common restriction reported was avoiding foods perceived to "induce cold," such as brinjal, papaya, yam, spinach, and oranges, with some FGD participants noting,

> *Although this practice has declined compared to the past, they still exist in our communities.*
>
> FGD participants, Rautahat

In Rautahat, foods like pumpkin and brinjal were avoided due to beliefs they delay postpartum wound healing, while green leafy vegetables were restricted in Kailali and Rautahat, as they were thought to cause green stool in newborns.

Nutritional malpractices were more prevalent in Rautahat, where some households restricted postpartum mothers to a diet of salt and rice, especially in families where mother-in-laws played a dominant role, continuing practices they experienced themselves. In Dailekh, a common practice was the restriction of milk products during the postpartum period and menstruation, influenced by Chhaupadi. A Female Community Health Volunteer (FCHV) explained this restriction as a long-standing belief.

In Surkhet, an FCHV shared how elderly generations believed fish should be avoided during pregnancy as

> *Fish bones may get into the baby sucking breast milk and get stuck in the stomach of the child.*
>
> FHCV, Surkhet

Although she noted this belief is less common today, restrictions on pulses and jackfruit persisted due to concerns they could cause abdominal issues, described as *"Bader" for the baby.* Additionally, some communities practiced giving newborns honey or water, believing it to be beneficial or necessary when breast milk seemed insufficient.

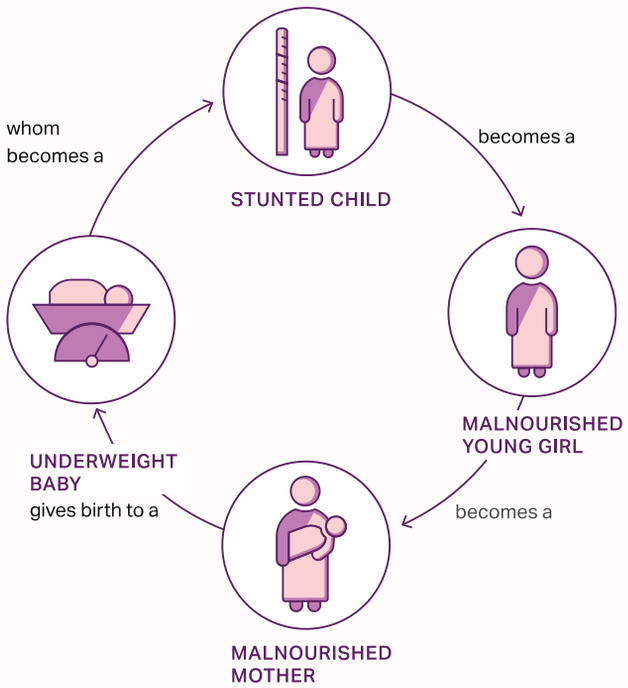
Social Norms and Dietary Behaviors

Social norms heavily influence maternal and child nutrition, with practices such as women eating last, limited decision-making power over food purchases, and male-dominated household dynamics restricting access to nutritious diets. Child and early marriage perpetuate cycles of malnutrition, with adolescent pregnancies exacerbating nutritional demands while limiting young mothers' access to resources.

A quantitative study which was simultaneously carried out with this qualitative study in the same study districts among

1,750 women aged 15-49 years revealed that a substantial proportion of women

39.3% were married before 18 and **67.6%** before 20, with the highest rates in districts like Banke **73.7%** and Rautahat **72%.**



The Gender-Equitable Men (GEM) Scale survey conducted in the same study districts revealed deeply rooted inequities, with 32.6% **of women** falling into the high inequity category, reflecting strong adherence to traditional norms limiting women's autonomy. District-wise, **Rautahat reported the highest level of inequity** 53.4%, followed by Banke 45.1%. Economic constraints, male migration, and cultural preferences for male children further impact nutrition, particularly in marginalized communities. While positive changes, such as shared responsibilities and community-led initiatives, are emerging, deeply ingrained norms and discriminatory practices remain significant barriers to improving maternal and child nutrition.

Below are some excerpts that highlights social norms and it's effect on maternal care and nutrition;

> *'The preference for a boy child still persists in the society, resulting larger family size if girl children are born simultaneously.'*
>
> *-KII, Community Leader, Banke*

This practice may result in several repercussions such as depletion of maternal nutritional stores due to frequent pregnancies, limited ability of mothers for post-partum recovery and malnutrition of mother and child due to coinciding of breastfeeding period.

> *"We provide nutritious food such as meat, fish, eggs milk etc. for lactating mothers but we can only manage it for around one month, and it is not possible to continuously provide these foods. Only rich can afford good and nutritious foods."*
>
> *-Man FGD Participant, Dailekh*

> *"Most of males in our community go abroad to earn money. So, women are not able to obtain enough support from their husbands."*
>
> *-FGD Participant, Surkhet*

> *"Traditionally, women were solely responsible for all kitchen-related tasks. However, over time, gender roles have gradually evolved. Today, it could be estimated that the division is around 70% women and 30% men."*
>
> *-Health Coordinator, Banke*

Cultural & Traditional Beliefs and Practices

Cultural beliefs and traditions significantly influence the nutritional status of pregnant and lactating women, with both positive and negative impacts. Some traditions support maternal nutrition, such as providing postpartum mothers with chicken or mutton soup and "Jwano soup," which are considered restorative and discouraging junk food, tobacco, and alcohol, support maternal health. *A community leader from Dailekh described a positive tradition where new mothers are invited for communal meals.* However, harmful practices persist, such as isolating postpartum mothers in animal sheds ("Goth") until the naming ceremony, which limits their access to nutritious food; reported from Banke. A project focal person from Banke explained, *"This practice negatively affects the nutrition of new mothers as they are isolated from the home kitchen."* Practices like *Chhaupadi* in Dailekh continue, where postpartum women are seen as impure and restricted from consuming milk products. Variations are noted across ethnic groups, with some Gurung, Magar, and Chaudhary communities offering local alcohol to warm postpartum mothers, while Dalit and Janajati communities often provide meat, unlike Brahmin/Chhetri families who prefer ghee and butter.

Intersection of Social Norms and Nutritional Malpractices

The intersection of social norms with malpractices exacerbates challenges. Women often face limited access to nutritious food as household purchasing decisions are predominantly controlled by men. Cultural norms, such as serving men first during meals and were notably prevalent in Rautahat, disadvantaging women who eat last and may receive inadequate portions. Also, social expectations for women to consume leftovers were widely observed. Restrictive norms in some Muslim communities' limit daughters-in-law's mobility, preventing them from participating in educational or health programs. One project coordinator in Rautahat observed, *"There is rare access for women (mainly newly married daughters-in-law) to move out from home and attend any educational programs."* Beyond social norms, poor economic status remains a major barrier, as lower-income families often provide the same food for lactating mothers as other household members. A focus group participant from Dailekh shared,

> *Rich people provide nutritious food to pregnant women and postpartum mothers, but in poor households, we tend to eat the same food as other family members.*
>
> FGD participants, Dailekh

Limited awareness about balanced diets and a preference for market foods over locally available options further compound the issue. Additionally, the open border with India introduces challenges such as disrupted health services due to migration and reduced local agricultural productivity, limiting access to nutrient-rich foods and increasing health risks from chemically treated imports.

Policy and Strategies Influencing Nutrition

Key informants highlighted the vital role of Female Community Health Volunteers (FCHVs) in promoting maternal and child health, including nutrition, through support for Antenatal Care (ANC), Postnatal Care (PNC), Vitamin A distribution, immunization, and awareness campaigns on pregnancy nutrition and institutional delivery. Local governments across project districts have implemented diverse strategies to address social norms affecting nutrition practices. In Banke's Duduwa Rural Municipality, the *'Door-to-Door Health Program'* mobilizes staff for child growth monitoring and nutrition awareness, while the *'Integrated Agriculture and Health Program'* provides seeds, veterinary services, and dairy support to improve household diets. Rautahat district has introduced

community-driven initiatives emphasizing food security and maternal health education. A financial incentive program across districts encourages girls' education and delayed marriage, with the belief that "educated mothers will be more aware of their children's health and nutrition." The Multi-Sector Nutrition Program (MSNP) further promotes dietary awareness and intersectoral collaboration, while some municipalities aim to achieve 'nutrition-friendly' status. However, gaps remain due to limited integration of agriculture in nutrition programs and insufficient reach to challenge harmful social norms discouraging diverse diets.

CONCLUSIONS

The study highlights a dual narrative: while maternal nutrition in Nepal has improved over time due to increased awareness and evolving roles, deep-rooted cultural and social norms, economic constraints, and limited awareness continue to pose significant challenges. Harmful practices like food taboos during pregnancy and postpartum, including avoiding green leafy vegetables and other vegetables and fruits such as papaya, brinjal wax gourd, yam, spinach, oranges believed to induce-cold, restricting milk products persists in the study districts.

Harmful traditions like Chhaupadi, postpartum confinement, misconceptions about foods, and inequitable gender norms impede progress, especially in districts like Rautahat where these issues are more severe. Conversely, positive practices and community-led efforts such as Banke's 'Door-to-Door Health Program' and 'Integrated Agriculture and Health Program', Rautahat's food security initiatives offer promise but face challenges due to limited agricultural integration and persistent harmful norms.

Addressing these gaps requires an integrated approach that leverages the strengths of existing traditions while challenging harmful practices. Gender-responsive, culturally sensitive, and economically feasible interventions must be prioritized to achieve lasting improvements in maternal nutrition. Additionally, addressing child marriage is crucial for breaking the cycle of malnutrition and empowering young women to make informed decision for themselves and their families.

RECOMMENDATIONS

To address the diverse cultural and traditional practices influencing maternal and child nutrition, district-specific and gender-responsive interventions are critical. The following recommendations are drawn based on the findings of the study:

- **Men and Women-Responsive Interventions:** Promote shared decision-making in households and engage male family members through workshops to emphasize their role in supporting maternal and child nutrition.
- **Enhance Women's Participation:** Develop strategies to increase mobility and autonomy of women, addressing cultural resistance from influential family members.
- **Nutrition Education:** Implement community programs to promote dietary diversity, practical cooking guidance, and campaigns to highlight the value of locally sourced, nutrient-dense foods.
- **Community-Level Interventions:** Conduct culturally sensitive health education to debunk dietary myths, encourage equitable mealtime practices, and promote positive traditions supporting maternal nutrition while discouraging harmful practices.
- **District-Specific Programs:** Focus on districts like Rautahat and Banke with tailored social and behavior change communication (SBCC) initiatives to address entrenched inequitable norms and early marriage.
- **Policy-Level Actions:** Train health workers and community stakeholders to track nutritional practices, and implement behavior change communication strategies to address harmful norms and promote sustainable, evidence-based solutions.

Suggested Citation

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