Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

Beyond Awareness: Governance, Structural Poverty and Nutritional Challenges among Musahars in Siraha, Nepal

Jhabindra Bhandari*
Central Department of Anthropology
Tribhuvan University, Nepal
talk2jhabindra@gmail.com

Yojan Basnet
Central Department of Anthropology
Tribhuvan University, Nepal
yojaninspace@gmail.com

Kabita Chaudhary
Padma Kanya Campus, Baghbazar,
Kathmandu, Nepal
kabitachaudhary84@gmail.com

Carine Magen-Fabregat
Action contre la Faim (ACF)
France
cmagenfabregat@actioncontrelafaim.org

Type of Research: Original Research
Corresponding author*
Received: July 25, 2025; Revised & Accepted: September 30, 2025

Abstract

Background: Nutritional disparities among Nepal's marginalized communities remain a critical public health concern, particularly in the context of federalization and shifting responsibilities for health governance. The Musahar community, among the most socio-economically excluded groups in Nepal, faces persistent challenges in accessing adequate nutrition and health services. While interventions have primarily emphasized awareness and behavior change, little attention has been paid to structural poverty and governance failures

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

that limit the effectiveness of such approaches. This study highlights that nutrition interventions must integrate poverty alleviation, inclusive governance, and cultural sensitivity into program design. It provides ethnographic evidence that can help the Ministry of Health and Population revise Nepal's Multi-Sector Nutrition Plan (MSNP) to ensure equity-focused, community-centered approaches

Methods: This study draws on two weeks of ethnographic fieldwork in Sakhuwanankarkatti Rural Municipality, Siraha district. Data were collected through 24 in-depth interviews, 3 focus group discussions, participant observation, and participatory resource mapping with Musahar households, local officials, health workers, and community volunteers. Data were analyzed thematically using practice theory to explore how everyday practices of food, health, and care are shaped by structural constraints. Informed verbal consent was secured from all participants.

Results: Findings show that despite increased awareness of nutrition, structural poverty, caste-based exclusion, and weak local governance prevent Musahar families from accessing diverse diets and consistent health services. Dietary taboos and traditional healing practices persist not as ignorance but as adaptive responses to poverty and exclusion. Federalization has not translated into improved service delivery: local governments face limited budgets, weak accountability, and dependence on NGOs for nutrition interventions. Trust deficits between communities and health institutions further undermine the effectiveness of nutrition programs.

Conclusion: Awareness-focused interventions alone cannot address the nutritional challenges faced by the Musahar community. Structural poverty, exclusion, and weak local governance under federalism reproduce health inequities despite policy commitments to inclusivity. Effective interventions must go beyond awareness-raising to address structural barriers, strengthen accountability in local governance, and enhance social protection for marginalized groups.

Key words*:* Musahar, nutrition, structural poverty, governance, federalization, Nepal

1. Introduction

On 26 July, 2024, it was a sunny day, but very hot weather in Siraha. We were excited for the fieldwork and so we moved towards Sakhuwankarkatti Rural Muncipality of Siraha district in the early afternoon to meet the municipality officials to introduce ourselves, purpose and the fieldwork we wanted to conduct in Musahar and other socially marginalized communities in order to understand their observations, lived experiences and everyday activities in search of better health and nutrition.

As we entered the municipality office, we first asked a woman inside the corridor who worked as support staff to locate whereabout of the health coordinator's office. At the side of room, a Health Coordinator was reviewing the health records and busy in reporting. But he welcomed us with a smile. After sharing our purpose of fieldwork in the communities where Musahars and other excluded groups are living around, he added with a bit of surprise and frustrations: "These people do not usually come to health facilities for health and nutrition services. No specific reason he explained so far, but hinted that they live in rural areas for centuries – often

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

in difficult social circumstances overwhelmed by economic and cultural marginalization, illiteracy, poor living conditions, little family support (from husband and/other members as they go for jobs outside), inability to afford transportation as well as medicines, early marriage/ pregnancy, and limited out-reach clinics or camps in those areas.

This gave us an interesting idea and insight about the perceptions of local government officials who are spearheading health and nutrition programmes across the municipality and how they make the narratives of Musahar's health and nutrition seeking behaviour in the communities in terms of access and utilization of services. This is particularly relevant and important context that we would like to explore the broader attitudes and perspectives of local government officials towards Musahar communities, and how these support or contrast with the views from these communities. Because we sensed that these perceptions show contrast between communities and service providers in local health systems.

After short conversations with the coordinator, we entered to Sakhuwankarkatti ward office – 4 where the Chairperson, a gentle man and political leader in his mid 40s was talking to a few visitors from the communities around. They seemed requesting for recommendations for some financial support, but exact details we could not sense, anyway. After a few minutes, we greeted him with a brief introduction and purpose. He commented: "They (Musahars) live on their own, have less interest and motivations to come to health workers or health posts for nutrition. And these people have serious health and nutrition issues, we know – especially among children and women. But what can we do ?" This version of his deep-rooted views again showed that the communities are not willing to access health and nutrition services in the health posts. The mind-set and perspectives from the community or political leaders are important to explore further in understanding inherent barriers of the communities.

Listening to his bold insistence on his dominating claims, we were interested to understand the observations, views and experiences from the communities what they had to say all about this story. Therefore, we wanted to explore further with those communities as well as a few more local government officials, community leaders, school teachers, religious/traditional healers, female community health volunteers, pharmacy owners, health workers, community media networks, and mothers' groups. To better understand the gaps or barriers in accessing health and nutrition services by these communities, our anthropological curiosity grew more, and we mapped out list of key stakeholders that included health and nutrition service providers from local governments as well as the community groups.

As part of local context, Siraha is one of the 8 districts in Madhesh Pradesh of southeastern Nepal. It is bordered by Udayapur district to the north, Saptari district to the east, Dhanusha district to the west, and the Indian state of Bihar to the south. It is known for its rich cultural heritage, agricultural economy, and diverse population. It is part of the Terai region, with flat plains and fertile soil. As of 2021 Census, the population is 700,000. The district is home to various ethnic groups, including Madhesi, Tharu, Maithili, Yadav, Chhetri, Musahars and Dalits.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

Despite decades of promises and millions spent on housing programs, the Musahar community in Madhesh remains landless and forgotten. Living in makeshift homes and relying on seasonal labor, their fight for basic rights to health, education and income security is met with systemic neglect and deep-rooted discrimination.

Their most widely spoken language is Maithili, followed by Nepali, Tharu, and other regional dialects. Hinduism is the predominant religion, with a smaller percentage of the population practicing Islam, Buddhism, and Christianity. There are 8 urban municipalities and 9 rural municipalities. Of the 9 rural municipalities, Sakhuwankarkatti is the one we chose to conduct the ethnographic fieldwork based on the consultations with local government officials, health post in-charges and local NGO representatives. The population of the municipality is around 20844 (CBS 2021), and local authorities estimate about 15 percent as Musahars and other socially marginalized communities.

Local government office record reveals that about 15 % infants are malnourished in Siraha. Health workers nearby the health post claim that children from rural and economically backward societies suffer from malnutrition because of lack of nutritious diet, food insecurity, poor housing conditions, lack of adequate water, sanitation and hygiene services.

The ethnographic fieldwork actually focused on rural Musahar communities of Sakhuwanankatti Rural Municipality in Siraha. Our interest and anthropological inquiry on health and nutrition narratives is important to generate evidences in uncovering lived experiences and meanings behind health practices as well as illustrate further on how structural inequalities shape their health and nutrition care . This municipality is in the mid-eastern part of the district as well as in southern part of East-West highway. We selected cluster of marginalized communities closer to municipality where Musahars, Chamars, Paswans and other marginalized communities have been living for centuries.

In the context of Nepal, malnutrition is not only a significant public health problem, but a socio-cultural issue. In this context, it was an attempt for us to understand the everyday life experiences of Musahars from socio-anthropological approach in the context of their perceptions, beliefs, understanding and access to health and nutrition services in the communities.

In a study (Shah et. al, 2016) demonstrated that undernutrition continues to be a serious problem in the Musahar community residing in Siraha. At least suffered from one of undernutrition children were 65% whereas the 10% children were suffered from all three undernutrition. It also revealed that the children of less than 24 months had 2.19 times higher risk of suffering from chronic malnutrition (stunting).

Nepal's constitution, 2015 has clearly articulated basic health care as a fundamental health right. In the federal context, national health policy, 2019 primarily aims to ensure access to quality health services for all. We closely witness that there have been significant changes in health policies, strategies and in Nepal after federalism. Equitable access to health care and social protection for marginalized sections of the communities is an important issue from health policy and strategic intervention perspective (MoHP, 2019).

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

Moreover, local governments are the administrative units on the frontline that provide public services in the federal structure, and are held accountable and responsible for addressing basic human rights including delivering health services. Federal and provincial legal and policy documents and guidelines provide the general framework for local governments to develop their local health policies and plans. The Local Government Operations Act 2017 (LGOA) provides ample opportunity and space for the local governments to prioritize their resources in meeting the health care needs of people who are historically marginalized and left behind (Bhandari, 2023). [1]

Health systems governance is a newly developed concept that largely refers to the rules and norms that shape roles and responsibilities, incentives and interactions in the health sector. Therefore, local governments play a major role in making inclusive health system through a broad range of legal, policy, planning and monitoring instruments where health service providers, both public and private, and inclusion of poor and marginalized communities to advance the achievement of universal health coverage.

Access to health services is the ability, or perceived ability, to reach health services or health facilities in terms of location, timeliness and ease of approach. It is central to universal health coverage, particularly for the most vulnerable and marginalized people in our societies. Still, many populations cannot access the care they need due to economic, geographic, epidemiological or cultural barriers. Engagement is the process of involving people and communities in the design, planning and delivery of health and nutrition services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be equitably distributed.

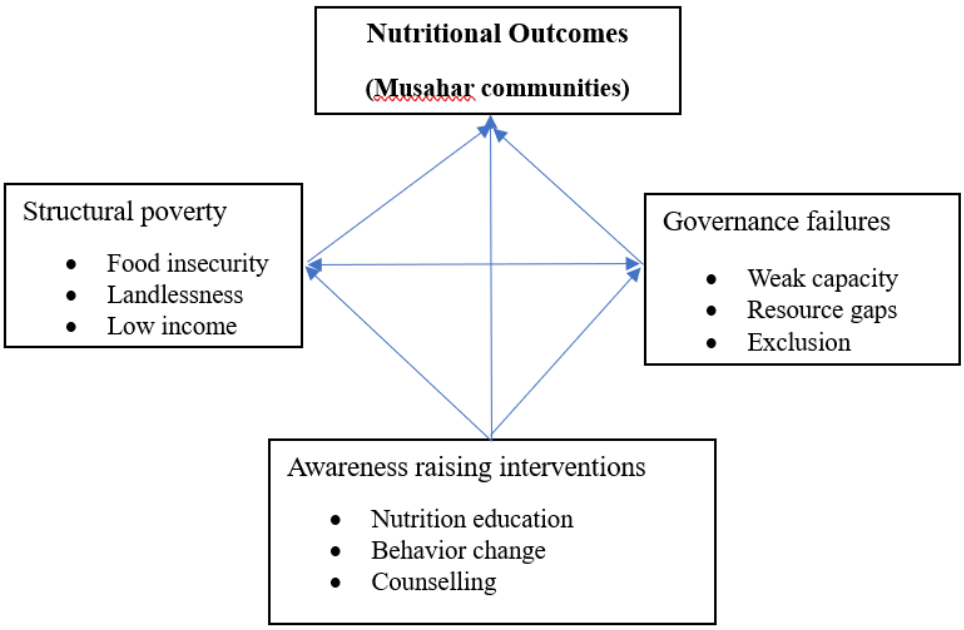
There are a very few studies in the federal context in terms of people's access to health and nutrition services – particularly by the poor and marginalized communities from an anthropological perspective. There is limited evidence on how local health governance is supporting or constraining marginalized communities' access to health and nutrition services. Earlier, there was no clear focus on the healthcare provision of disadvantaged and marginalized populations. Local governments had limited political autonomy to prioritise their resources in the health sector. After implementing federalism, these governments are more accountable and responsible towards addressing basic human rights, including health services (Bhandari, 2023). However, in case of the municipality we visited, surprisingly, there is no significant change in delivering health, nutrition and other social protection services to the marginalized communities.

In this paper, we use the notion of structural poverty to refer to long-term and structural forms of deprivation that transcend income or awareness, and are reproduced by differential social, political, and economic ordering (Farmer, 2004; Sen, 1981). Poverty among Musahar communities is experienced through landlessness, caste-based exclusion, precarious wage employment, and state bureaucratic denial of access to state entitlements.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

The conceptual framework is illustrated in Figure 1 shows how nutritional outcomes are shaped by structural poverty, governance and awareness raising interventions.

Structural Poverty, Governance and Awareness Raising Interventions Shaping Nutritional Outcomes



Linking our arguments, we draw on practice theory as developed in anthropology and sociology (Bourdieu, 1990; Giddens, 1984; Ortner, 2006). Practice theory explores how everyday practices whether they are food choices, health-seeking, or caregiving, are shaped by broad structures of power, poverty, and governance, and yet also reproduce, or subtly transform, such structures. Theories such as Bourdieu's notion of habitus allow us to consider Musahar dietary practices not as stagnant tradition but as adaptive responses to material deprivation and historical exclusion. In the same line, Giddens' structuration theory highlights the duality of agency and structure whereby Musahar households navigate biomedical care, traditional healers, and bureaucratic hurdles, thereby negotiating but also reproducing the constraints they face. Moreover, Michel Foucault's concept of governmentality is also relevant here as it is all about how governments, organizations and even individuals manage and control people in society. This included various forms of relations such as interpersonal relations, relations in social institutions and communities, and relations with self, but what concerned Foucault the most was the relations in the political domain, i.e., relations concerning the exercise of political sovereignty (Gordon, 1991).

In applying this model, we aim to situate Musahars' health and nutrition practices within the context of the interplay among structural poverty, caste marginality, and governance systems, and also highlight how communities bargain for agency in conditions of uncertainty.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

2. Methods

2.1 Study Design

This research employed an ethnographic design within an interpretative paradigm, focusing on the lived experiences of Musahar communities in Siraha district. Ethnography was chosen to capture everyday practices, narratives, and interactions that shape health and nutrition access in marginalized contexts, providing insights that quantitative surveys often miss.

2.2 Study Site

Fieldwork was conducted in Sakhuwanankarkatti Rural Municipality, Siraha district, located in Madhesh Province, southeastern Nepal. The site was selected in consultation with local officials and NGO representatives due to its sizeable Musahar population and high prevalence of malnutrition among children.

2.3 Data Collection

Fieldwork was carried out over a two-week period in July–August 2024. A combination of qualitative techniques was used to ensure depth and triangulation:

- **In-depth interviews (n = 24):** conducted with Musahar mothers, fathers, elders, traditional healers, community leaders, and local government officials.
- **Focus group discussions (n = 3):** with Musahar women's groups and youth groups to explore collective perspectives on food, health, and nutrition.
- **Participant observation:** daily activities and food practices were observed in households and community events, with fieldnotes recorded systematically.
- **Participatory resource mapping:** carried out with community members to document access points to health facilities, sources of food, and environmental challenges.

Interviews and discussions were conducted primarily in Maithili and Nepali, with the support of local translators where necessary. One of our research team members was Kabita Chaudhari who was fluent in Maithili and facilitated the interviews and discussions with mothers and other groups in Maithili. All interactions were audio-recorded with consent and later transcribed and translated into English for analysis.

2.4 Data Analysis

The data were analyzed thematically, following Braun and Clarke's (2006) approach to qualitative thematic analysis. Transcripts and fieldnotes were coded inductively and deductively using NVivo software. Emerging themes were refined through multiple rounds of coding. Practice theory (Bourdieu, Giddens) guided interpretation, emphasizing how structural constraints (poverty, caste, governance) shape everyday practices of food, health-seeking, and care. Reflexive memos were kept throughout to ensure transparency in interpretation.

2.5 Researcher Positionality and Reflexivity

The research team consisted of anthropologists and public health scholars with prior experience working with marginalized groups in Nepal. The lead author is affiliated with both academia and a humanitarian NGO 'ACF-France), which facilitated access to communities but also required sensitivity to potential perceptions of power and institutional affiliation.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

Reflexive practices, including team debriefings and critical self-questioning, were employed to minimize bias and remain attentive to participants' voices.

2.6 Limitations

This study has several limitations. The fieldwork was relatively short in duration (two weeks) and concentrated in one municipality, which may limit generalizability. As with all ethnographic research, findings reflect the perspectives of the participants engaged, and certain voices (e.g., men migrating abroad) were underrepresented. Despite these limitations, the study provides in-depth insights into the systemic challenges facing Musahar communities.

2.7 Ethical Considerations

Verbal informed consent was obtained from all participants, who were assured of anonymity and the voluntary nature of their participation. Sensitive information was handled with confidentiality, and pseudonyms are used throughout the paper.

Within the framework of the interpretative paradigm, we used ethnographic methods specifically and qualitative methods more generally to provide a contextual understanding of nutrition among the communities as noted by Taylor et al. (2012). In the next sections, we summarize key observations and findings from the fieldwork.

Data were collected both in Nepali and Maithili languages. Nepali was the prevalent interview and conversational language, but older Musahar interlocutors from different villages spoke mostly in Maithili. For those cases, one of our research team members (Kabita Chaudhary) facilitated most of the conversations, translations, and interpretations.

3. Results

3.1 Health and nutrition narratives in the communities

A young mother carrying her daughter (2 years old) comes to join a group meeting of mothers in Musahar community, and wondered if there is any support or health clinics to be organized. Showing her child suffering from malnutrition and other health issues, she asked us: " Will you give us medicine or help treat us ? We were a bit nervous and surpised as it was an unexpected question for us. Worryingly added she further: We (Musahars) are suffering from health and nutrition issues for many years. It is our *'dukh'* (sadness) and *durbhagya* (misfortune), and I wonder why we face such *dukh* and social insecurity." We made a follow up conversations with her to know why they do not go to health posts. " It is far from here, we do not have money to afford transportation costs. Even if we manage to go there, we do not get medicines and proper treatment. They (health workers) refer us to go to private clinics for medicines, and we can't afford it. So, why should we go there? We do not have any support (indicating financial) from ward office as well as municipality for us. Our hopes are declining over time"

This testimony illustrates more than individual suffering, it reveals how structural barriers such as poverty, geographic isolation, health system inefficiency, and lack of institutional support converge to reproduce cycles of ill-health. Her invocation of *dukh* and *durbhagya* not only expresses emotional distress but also frames health inequality as a collective misfortune, deeply embedded in socio-political marginalization. From an anthropological perspective, such

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

narratives highlight how experiences of illness are entangled with broader structures of exclusion, reinforcing why biomedical interventions alone cannot address the problem (Harper, 2014).

As we observed and had a good sense of the voices of these communities, seeking health, nutrition and dietary habits among Musahars and other socially marginalized communities are still determined and shaped by institutional access, socio-eonomic status, cultural beliefs and practices. Certain foods are restricted during specific life stages such as pregnancy, postpartum, or when ill. As an elderly put it, "Some fruits shouldn't be given… fish and meats should be avoided after delivery." These social restrictions, albeit intended to protect, often result in nutritional compromises at the very life stages when women and children require high-nutrient diets. These traditions co-exist with an increasing knowledge of modern principles of nutrition, but knowledge is uneven and mediated more through kin and neighbors than through health education in the formal sense.

In addition, we also wanted to explore the dietary habit of the communities and how this has changed overtime. During informal interactions with mothers, leaders, female community health volunteers, elderly people, Traditional staples like millet (*kodo*), which were once widely cultivated and consumed, have now largely disappeared from the local diet in favor of rice. An explanation came from a retired school teacher: "During our grandfather's time, we had a good crop of *Kodo* (Millet)… nowadays those millets are not there anymore." This shift not only reflects changing agricultural systems made possible by irrigation and pumps but also a decline in dietary diversity, as protein-rich millets gave way to carbohydrate-rich rice. The memory of millet as a "healthier" crop also suggests historical awareness of its nutritional value, even if production and consumption patterns may have changed.

These traditions and practices cannot be separated and overlooked from the perspective of structural poverty and caste marginality. As one woman stated, "What we get, so we can eat." If we can't afford, then how we can consume it? This is the fate of poor." Thus, traditional nutrition is not a cultural inertia but it is an adaptive response under severe constraints. The employment of extended breast-feeding, dietary taboos, or herbal medicines is a sign of efforts to sustain life where access to diverse diets, consistent health care, and governmental services is precarious.

3.2 Historical changes in food habits

Musahars' food habits exhibit both significant transformation and persisting challenges, shaped by broader historical, economic, and social forces. The introduction of electricity, irrigation, and motor pumps created new opportunities for farming, and increased access to markets expanded the variety of available foods. At the same time, both internal and international labor migration for wages has boosted household income, which has helped households to purchase more types of foods than before. As one of the villagers remembered, "When I was a child, we didn't have enough availability of foods… In the past, we used to eat what was available in the field and house. Now individuals eat types of food stuff like meat, vegetable and fruit." Such characterizations indicate a generational change from subsistence-oriented diets rooted in local

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

production to greater dependence on purchased and diversified foods, made possible in large measure by remittances and changing livelihoods.

But improvements in access and availability have not solved underlying vulnerabilities. The rural municipality chairperson pointed out that "women during pregnancy and after delivery period need nutritious food … but for the weak economic status families it is difficult even to arrange one meal a day." This underlines the paradox of nutritional aspirations and awareness of the need for sufficient and varied food is widespread, but poverty is a continuing constraint to its realization. Moreover, the local governments do not have any concrete plans and resources to address these critical needs of health and nutrition care for the marginalized communities.

Generational narratives also suggest ambivalent perceptions of health change. Older Musahar residents recall periods of scarcity when there was nothing but salt, pepper, and rice to consume, but also perceive modern diets as both more varied and ironically linked to new children's health problems. The ward chairperson commented that "many children are born with types of sicknesses… children walk and talk very late," reflecting concerns about declining child health despite improved food availability. These perceptions reflect the intertwining of nutrition, environment, and health transitions in local experience.

3.3 Persistent misconceptions

Despite gradual shifts in dietary practices in the context of growing modernity and increased exposure to biomedical advice, significant misconceptions underlie health and nutrition discourses throughout Musahar communities. On the most basic level, food is consistently equated with fullness rather than nutritional content. As one teacher explained, widespread perception dictates that "children need to fill their bellies," irrespective of dietary balance. This knowledge reveals how hunger, rather than nutritious food, has been the dominant framework within which food is understood historically. Malnutrition is then reduced to a problem of discipline or eating "on time," rather than being recognized as an outcome of structural lack.

This was more evident in our interaction with local government officials, public health professionals, development workers, as many of them link malnutrition to the issue of lack of awareness and behavior and practices. While in our interactions with the communities, they were more concerned about earning for a day's meal and filling stomach. When asked about nutrition, they replied they feed children what they could gather and buy at the need of the day . What they eat is so provided to their children. So, their concern is not on fulfilling daily nutrition but rather fulfilling on basic level to survive and fill stomach.

Traditional illness concepts also muddle biomedical communication. Diarrhea, weakness, or failure to grow can still be attributed to spirit possession, and families will seek healers for ritual treatment. Healers themselves, nevertheless, recognize boundaries: while claiming a monopoly on supernatural illness, they also send parents to hospitals for physical illness. This ambivalence reflects how traditional and biomedical systems coexist, but also how uncertainty about illness causation promotes delay in seeking appropriate care. This illustrates health care systems as linked to medical pluralism

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

Intergenerational taboos also still shape child-feeding practices in directions that differ from biomedical advice. Elders recall prohibitions on yogurt, bananas, and certain local fruits, foods now recommended by health workers. Similarly, traditions of extended exclusive breastfeeding sometimes for as much as two years before complementary foods are introduced still delay adequate child nutrition. These practices reflect how older cultural logics still endure even as biomedical advice is disseminated in the everyday life of the communities.

Community narratives also reflect broader anxieties about modernity and farming. Concerns about chemical fertilizers "affecting all people" illustrate a moral appraisal of changing food systems, whereby nutritional decline is blamed not merely on poverty but on alleged contamination of the environment. Malnutrition, on the other hand, is frequently framed as an "education problem," over-attributed to *Dalit* and Musahar households. Such accounts often spoken by outsiders divert attention from structural inequities constraining access to diverse diets, reinforcing stigmatizing biases that portray the poor as ignorant or irresponsible. Rumors of misallocating nutrition incentives to buy alcohol also illustrate how social assumptions about Musahar families are shaped by prejudice instead of evidence, planting seeds of mistrust between communities and institutions.

Even where nutrition knowledge has begun to trickle in, for example, that "milk, fish, meat, and green leaves" are healthy, but poverty effectively limits the ability to act on such knowledge. As one woman put it, "What we get, so we can eat. If we can't afford, then how can we eat it? This is the fate of poor." Nutrition here is a want continually thwarted by economic exclusion. And those who can not afford are becoming vulnerable to food insecurity, poor health and nutrition.

Thus, such deep rooted perceptions and misunderstandings are not simply failures of knowledge transfer but a product of historic marginalization, poverty, and cultural continuity. These circumstances reveal that a group of marginalized communities such as Musahars practicing similar trends of accessing health and nutrition services in the communities, and there is little progress in it. Practice theory explains how such misperceptions are reproduced: they are invested in socio-economic structures, inter-generational lessons, and partial inclusion in formal health systems. In this context, the theory also highlights how there are differences in the motives and intentions of different human beings, and how they adjust, adapt and transform their world where they live (Bourdieu 1990).

3.4 Access and positionality experiences in health and nutrition care

Though health posts are formally present often situated near municipality offices and along road corridors in the rural municipality, may Musahars and other *dalit* families regularly illustrate how geography and institutional configurations continue to delimit care. Seasonal landscapes impose particular sufferings. In Jhutki village of Lahan Municipality, for example, families must traverse through rivers to reach the health post, a journey that becomes dangerous or impossible with the onset of monsoon floods. These physical obstacles reinforce the sense of being cut off from health services, creating what residents describe as "isolation" from structured care.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

In Nepal, there are both nutrition-specific and nutrition-sensitive interventions in tackling the malnutrition (MSNP: 2023-2030) that seeks to strengthen nutrition services through Management of Severe Malnutrition (MAM) at health facilities as well engage other social sectors such as education, agriculture, waster and sanitation and so forth to strengthen multi-sector actions on nutrition. The focal point for MSNP at the municipality who is locally recruited says: "There are no activities for MSNP except a few orientation at the municipal level. Coordination is with other sectors is limited to reach out health and nutrition campaigns in the rural areas where Musahars and other marginalized groups are living. At the health post, there is limited human resources to provide health and nutrition service.

While we observed the health post nearby, it has a few rooms, and a health care provider was registering a child and started weighing outside, gave vaccines and other counseling outside of the HP. " We lack sufficient rooms (space) to provide health and nutrition services. Look at only two small rooms." As part of implementation, there are critical barriers and bottlenecks in terms of systemic geographic constraints, limited human resources in nutrition, poor health infrastructure, heavy reliance on development partners and NGOs. The HP in-charge explained that in the past there were a few NGOs working here to empower the Musahars and other socially excluded groups for their easy access to education, health and nutrition services. But now, they do not exist and said, "From our side, we can not go those areas because we are busy in the HP, and have no other staff to reach out there. From the municipality, there are no activities or interventions targeted to them." Even where outreach centers exist, coverage is uneven: some wards have operational Outpatient Therapeutic Centers (OTCs), while others lack any space whatsoever to operate. More specialized care is constrained by limited budgets, with local allocations viewed as insufficient to sustain nutrition programs. These input limitations are sharply felt at the local level.

There are a few social protection schemes from the federal governments, but are not easily accessible to these marginalized communities. Bureaucratic hurdles and deficiencies also restrict access. A registration officer at the municipality disclosed: " We have seen lot of cases of people not getting their re-registration of nutrition incentive card in time. For instance, husband might be in abroad and wife goes to her parents' house for a long time. When she returns back and hears from the community that they are being provided with the nutrition incentive, she also goes to the bank but finds out that she hasn't re-registered in the ward office."

Added he further: "Some people who have knowledge about the process of re-registration can still forget about these things. We have electronic fund transfer (EFT) system. We find out through online system whose account hasn't been deposited nutrition incentive. But for these marginalized populations it has been difficult for them to comply with the systems on time as some of them still lack citizenship and other supporting details."

In order to receive nutrition-related incentives, families must navigate a complicated process of securing birth certificates, opening joint bank accounts, and re-registering annually. Inability to meet these time constraints often because of migration, seasonal absence, or merely lack of

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

information results in exclusion from support. Such a rigid system puts the poorest households, least able to cope with bureaucratic requirements, most at risk of falling outside of entitlements. These barriers also affect perceptions and trust. Many women grumbled that government medicines "never work," but private doctors are believed to provide good care. These testimonies illustrate how stock-outs, inefficient supply chains, and bureaucratic procedures not only undermine services but also erode community trust in public health systems. In practice, households are compelled to shuttle between multiple care options: government health posts, private clinics, or traditional healers, depending on availability, affordability, and perceived quality.

Thus, the systemic and geographical obstacles to Musahar communities highlight that access to nutrition and health care is not simply an issue of physical remoteness, but of structural exclusion. Landlessness and poverty perpetuate dietary monotony—"if there are no vegetables, we eat salt and rice only" and weak institutional accountability limits the coverage of nutrition interventions.

On the other side, caste and gender remain inextricably interconnected in shaping Musahar and other *dalit groups'* access to health and nutrition care. Despite the rhetoric of inclusiveness, they are structurally excluded from community and institutional spaces such as Health Facility Management Committees (HFMCs). Their lack of presence is not simply an issue of non-participation, but a structural positionality that positions Dalits as recipients rather than decision-makers in health governance.

Gender and caste intersect to shape nutrition at the household level. Although women report controlling daily kitchen decisions, this control is conditional: the fathers-in-law, mothers-in-law, and head men of households tend to determine what is purchased, prepared, and served. Structural patriarchy adds to poverty in displacing care work responsibilities. Women who engage in wage labor often leave child care to older daughters, perpetuating cycles of malnutrition. Feeding practices remain gendered, with health workers noting sons are prioritized over daughters in both diet and healthcare-seeking.

In this sense, gender and caste positionality not only mediate inclusion in nutrition care but also decide the very terms on which inclusion is negotiated. Belonging is partial and contingent: *dalit* women are spoken to as "beneficiaries" of interventions but not included in decision-making spaces; they act with agency in fields and kitchens, but within structures that reinforce their marginality. This stratified positionality highlights how health and nutrition disparities are recreated at the intersection of caste stigma, patriarchal authority, and systemic neglect.

3.5 Local nutrition governance and community systems

Asked some questions about inclusive nutrition governance with Chairperson of the Municipality, political leaders and relevant officials, their understanding and knowledge on how local government can be more accountable and responsive to the health and nutrition care needs of the Musahar and other marginalized communities, a mixed response was notably not appealing for the inclusion and benefits of these communities in many aways.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

In one hand, local communities and leaders complain lack of transparency, out-reach and allocation of resources for improving health and nutritional needs of the marginalized communities. "We do not know anything about the provision and benefits (cash transfer or other packages) about health and nutrition services from the ward office and municipality. We heard there is some allocation for us, but they (officials or service providers) never tell us when and how we can access to these resources. A community leader representing marginalized communities was very concerned and angrily commented: " There is no local government at all for us – we do not get any support or communications. This is truly frustrating us – they take (eat) the budget on their own benefit, hinting some level of corruptions there. No events or programs for us in the communities."

On the other side, local government officials and health care providers do not agree what they (communities) comment about access to health and nutrition services. They do not want to come with demands for discussions, a sign of mistrust is visible. However, there is no allocation of additional resources (budget) for targeted marginalized communities to improve their health and nutrition status. Neither concrete nutrition-specific and nutrition-sensitive interventions are planned in the spirit of multi-sector nutrition plan. There is no presence of any NGO in the communities, and no plan for NGOs' engagement for awareness and facilitating communities to better access health and nutrition services. A local leader said: " They do not come here for consultations or any meetings to share detailed health and nutrition activities, nor they do invite or engage us in the discussions at the municipality or ward level meetings." A woman in her early 30s said: "In the municipality and ward level committees, we are not represented from the marginalized communities – they do not care us, revealing discrimination and exclusion in the health and nutrition mainstream."

While Female Community Health Volunteers (FCHVs) role is very important in raising awareness on health and nutrition issues, they are not effectively mobilized. As one health worker explained, "FCHV are also part of the community health system. Whatever information we need to disseminate among public, they do accordingly." Their function illustrates how community networks are mobilized to penetrate otherwise marginalized households and extend the reach of formal health institutions.

Hower, the FCHVs embody a paradox of health governance: they are vital care-bringing actors to the margins, yet under-trained, under-valued, under-supported, and placed in asymmetrical power dynamics. Strengthening their training, recognition, and integration into the health system, alongside investments in health infrastructure development, would address the persistent gaps in access and translate into greater inclusion of varied Musahar communities.

Taken together, these examples point to a range of opportunities embedded within existing interventions: therapeutic and supplementary feeding, state and NGO incentives, livelihood supports, collaboration with traditional healers, and incremental changes in awareness. These opportunities reveal how nutrition programs, when culturally and structurally attuned, can generate tangible improvements in child health even within marginalized and resource-constrained settings.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

While nutrition interventions create new social protection opportunities, their effectiveness is often undermined by deep-seated socio-economic and systemic constraints leading to poor health and nutrition governance at local level. Ward leaders themselves admitted that they lack autonomy to design locally responsive nutrition programs, relying instead on budgets and plans framed at higher levels or through external partners. This dependence not only weakens local ownership but also creates delays and inefficiencies, as illustrated by budgets frozen when planned cooperative distributions failed to materialize.

Economic hardship constitutes the most immediate constraint. Families repeatedly emphasized that incentives or supplements, though well-intentioned, could not be reserved for child nutrition alone. Cash transfers were commonly diverted to household groceries, while in-kind distributions such as poultry or vegetable seeds were often consumed or sold quickly, leaving "empty bird cages" and barren gardens in their wake. Such outcomes reflect not negligence but survival-driven priorities: in contexts where rice itself is scarce, spending on vegetables or sustaining nutrition-sensitive assets becomes untenable. As one woman succinctly explained, "If we can't afford, then how can we eat it?." This is the deepening state of poverty and vulnerability of the marginalized communities."

Poverty also shapes dietary limits in more subtle ways. Even when families expressed awareness of nutritional foods, they lacked the means to regularly include vegetables, meat, or milk in daily meals. For pregnant women, micronutrient supplements were often inaccessible: while government supply was irregular, households could not afford to purchase alternatives from the market. In practice, most women reported never completing the recommended supplement courses. Recalling her memories a woman during group discussions claimed: " We approached HP for the supplements, but they said it is out of stock for now, will be available after weeks or months." Another woman added: " How can we trust nutrition services from the HP, if we do get the supplements and other medicines on time ?" These gaps underscore how structural deprivation systematically undermines the potential of biomedical interventions.

Systemic barriers compound these economic constraints. Registration requirements for nutrition incentives proved particularly exclusionary, as seasonal migration, husbands working abroad, and women's mobility between marital and natal homes often interrupted eligibility. Even those who were aware of the process admitted to forgetting re-registration deadlines, resulting in lost benefits. Meanwhile, irregular supply chains further eroded trust: health workers themselves noted that stocks of RUTF or therapeutic supplements were often exhausted before cases could be fully treated. Such failures amplify community perceptions of ineffectiveness, driving families back to traditional healers when biomedical services appear unreliable.

These intertwined economic and systemic barriers expose the fragility of nutrition interventions in marginalized settings. Programs that frame families as "unserious" about nutrition risk obscuring the structural realities of poverty, precarity, and weak institutional support. Belonging theory helps explain these dynamics: Musahar and Dalit households experience exclusion not only from economic resources but also from reliable institutional care, leaving

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

them unable to participate equally in state-promoted health and nutrition frameworks. Agency is present—in women's efforts to access care or make use of incentives—but it is repeatedly constrained by poverty, by bureaucratic rigidity, and by the uneven performance of local systems.

Ultimately, these constraints highlight that without addressing underlying socio-economic deprivation and systemic neglect, nutrition programs risk reproducing inequities rather than overcoming them.

3.6 Community perceptions on nutrition interventions

Community perceptions of nutrition interventions are shaped by experiences of distrust, exclusion, and expectation failure. A number of participants were suspicious of the usefulness of health services, especially where programs had little to offer except counseling. As one woman described, people have the impression that health posts "only advise but don't provide anything." This is reflective of broader distrust of preventive care, as health-seeking behavior remains largely reactive and dependent on external aid in preference to self-motivated. This was corroborated in field observations in which families scarcely ever considered how to prevent children from being malnourished on their own, but instead waited for external aid.

Health-seeking behavior is not linear but dynamic, oscillating between biomedical and ritual spaces. As a son of a healer explained, he could not assure if people went to access care at the health post or began by consulting ritual healers, such a detail that demonstrates coexistence and context-specific prioritization of healing systems. Interventions based on the assumption of automatic priority for biomedical care might consequently be oblivious to pragmatic pluralism that functions in decision-making in communities.

Mistrust also went as far as extending to NGOs and government agencies. Local chairpersons and community members criticized past NGO efforts as short-lived and directed more towards empowering staff rather than addressing community needs. Similarly, public health facilities were described as ineffectual and unpredictable, with some participants showing a preference for private sector treatment. Fear and stigma also impacted on maternal health-seeking behavior; some women reported to avoid hospitals because they expected scolding or mistreatment from doctors and nurses. These events reinforce the perception of formal systems being inaccessible and unhelpful.

Even when nutrition incentives were provided, they were readily subverted in their original purpose by families. As one family illustrated, incentives provided every four months were readily used to purchase rice, lentils, and vegetables for general survival needs. This functional diversion illustrates how poverty constrains the ability to follow program prescriptions, turning nutrition-targeted interventions into more general subsistence support.

4. Discussion

In this paper, we present an ethnographic illustration of how local governance and structural poverty are impacting on nutritional outcomes among Musahar families. The research reveals how the Musahar community's health and nutrition practices are put together at the intersection of structural poverty, caste marginality, and the governance failure. Practice theory as

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

governmentality provides an effective theoretical framework to help explain these dynamics, which identify how ordinary activities are put into place by overarching social circumstances but also reproduce and transform them.

Pierre Bourdieu's (1990) concept of habitus proves particularly useful at this point as Musahar dietary practices, such as reliance on rice rather than traditional millet or obedience to postpartum food taboos, are not so much cultural momentum but conditioned practical responses based on poverty, market possibilities, and intergenerational convention. These embodied dispositions reflect a history of exclusion and adaptation where what people eat ("what we get, so we can eat") is simultaneously a product of material restriction and socially learned survival strategies. The narratives of Musahar women invoking "dukh" (sadness) and "durbhagya" (misfortune) are a performance of a habitus internalized over generations of exclusion. Anthony Giddens' (1984) structuration theory further illustrates how Musahar families perform both within and against structures of health governance.

The traditional health-seeking practices and behaviours illustrate Giddens' duality of structure concept implying structures enable and constrain action, since action simultaneously reproduces or resists those structures. Incorporating Foucault's (1980) power and governmentality makes this analysis even more complicated, illustrating how nutrition governance in Nepal is a form of biopower that manages marginalized bodies but strengthens exclusion.

The findings unveil how health systems and local governments exercise disciplinary power through demanding registration processes and asymmetric resource allocation, literally governing Musahar populations at a distance by framing them as "beneficiaries" in lieu of participants. This is in line with Foucault's conceptualization of power as productive yet dispersed, such that discourses of "awareness deficits" among Dalits deflect attention from structural injustices, stigmatizing communities as irresponsible and legitimizing caste hierarchies. However, the finding also challenges Foucault's emphasis on top-down power by showing examples of resistance like pragmatic deflection of incentives towards domestic sustenance by women, which challenges purely deterministic views. This is consistent with Foucault being criticized for minimizing agency (Haugaard, 2021), suggesting that his work needs to be integrated with Bourdieu's and Giddens' to more rightly capture how power configures but also contested within everyday nutrition practice.

Current anthropological scholarship of practice theory has emphasized the relational and adaptive character of everyday tactics in uncertain contexts. Ortner (2006), for instance, argues that practice theory bridges the space between agency and structural reproduction and accounts for how marginalized people act resourcefully within systems that operate against them. In our study, practices like extended breastfeeding or diverting nutrition gains to household needs are adaptive habits that register agency as much as constraint. These are not error or "misuses" of programs so much as embodied negotiations of survival in situations under structural poverty. Ortner's (2006) call for an anthropology of practice that is more dynamic, incorporating subjectivity and power struggles by highlighting how gender and caste intersect to mediate

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

agency in feeding decisions in the household. For regulation of nutrition, Cuj et al., (2020) applies practice theory to food policy and illustrates how "nutritious" food categories in Guatemala exclude local practices, just like the Nepali health system fails to include and understand Musahar taboos and practices.

Thus, Musahars' nutrition practices are not static traditions or knowledge gaps, but embodied, adaptive practices in structurally unequal social relations. This perspective identifies how narrowly awareness-based interventions failed because they ignore the structural conditions of poverty, landlessness, bureaucratization-induced marginalization, and exclusion through caste that determine the limits of what households can hold in material terms and get access to. Addressing nutritional inequities therefore requires more than technical interventions but structural shifts that heighten entitlements, build local governments, and embrace the lived practices of the marginalized. Though Bourdieu (1990) and Giddens (1984) provide the first tools of comprehension of habituated marginalization, more current research like Ulijaszek (2024) and Ji and Cheng (2021) promote interdisciplinarity through anthropocentrism debates, demanding equity models. Studies should continue to analyze these contradictions, perhaps through Reckwitz's (2002) culturalist grasp of social practices, in order to guide policies that empower, not dominate marginalized groups.

5. Conclusion

From our ethnographic field research, we concluded that access to health and nutrition for Musahar and other marginalized communities is not only shaped by historical, social, cultural, economic and political contexts, but also the interest, motivations and capacity of local government to facilitate the communities in meeting their immediate health and nutritional needs within health systems and beyond. Together, our analysis also reveals that conventional ways of nutrition interventions focusing only on awareness fail because they ignore structural poverty and exclusion. Poverty leads to increased vulnerability, with those living poverty facing higher rates of hunger and malnutrition, particularly among children and youth (Sen, 1981). Additionally, Mushars are well aware of the importance of nutrition while maintaining traditional ideas, but they face barriers to have material means to acquire nutrition or claim social protection from the local government. This requires communities to have a) ownership of land/ assets, b) wage labour, c) citizenship claim from the local government, and d) charity/ gift/ social networks. Sustainable improvements in nutrition will depend on programs that recognize the lived realities of Musahar households where agency exists but is repeatedly constrained and that address the deeper socio-economic, institutional and governance barriers reproducing malnutrition across generations.

This research challenges the notion of traditional systems, local narratives of nutrition, the intention, willingness and capacity of local governments in facilitating effective implementation of nutrition-sensitive interventions in multi-sector approach targeted to Musahars and other marginalized communities. Furthermore, it emphasizes how empowering the marginalized communities can break the existing socio-political and cultural barriers in accessing health and nutrition services in the communities. By doing so, the communities aim

to improve their agency in improving their health and nutritional status through health promotion and leveraging social capital and networks. There are a couple of issues that are raised and critical for policy implications. These are in the area of strengthening social protection and subsidies, addressing governance failures lacking inclusivity and accountability, recognition and support for FCHVs, and design culturally sensitive, but structurally grounded nutrition-sensitive interventions targeted to Musahars and other socially marginalized communities.

Acknowledgments

First and foremost, we are deeply indebted to Carine Magen-Fabregat, Action Contre la Faim (ACF), France for her encouragement and support in reviewing the manuscript for comments and insightful inputs. In addition, we are grateful to Dr. Ojaswi Acharya and Ranjan Kapali, ACF Nepal for their support during the planning and completion of ethnographic research. Our deep appreciation and huge thanks to Prof. Dr. Jeevan R. Sharma and Dr. Avash Piya for review, support and inputs over the draft. We would also like to express our gratitude to our research participants and all those who supported us throughout ethnographic field research.

Ethics Approval and Consent to Participate

We obtained verbal consent from our research participants and ensured their anonymity. We also coordinated with Nutrition Section of Family Welfare Division, Department of Health Services for conducting the research and obtained verbal consent from Sakhuwankarkatti Rural Municipality and Health Post Staff during fieldwork. This ethnographic field was conducted in team and for ACF Nepal.

Competing Interests

There are no competing interests in this study.

Funding

ACF Nepal provided funding for field research.

Authors' Contributions

Jhabindra Bhandari contributed to overall research design, methodology, data collection, analysis, and drafting the manuscript. Carine Magen-Fabregat provided significant inputs and guidance over the draft, Yojan Basnet and Kabita Chaudhary helped in data collection, analysis and formatting.

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

References

Bhandari, J. (2023, November 1). Towards an inclusive health system. *The Kathmandu Post*. https://kathmandupost.com/columns/2023/11/01/towards-an-inclusive-health-system

Bourdieu, P. (1990). *The logic of practice*. Stanford University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Gordon, C. (1991). Governmental rationality: An introduction. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 1–52). The University of Chicago Press.

Bourdieu, P. (2008). Outline of a theory of practice. In S. Seidman & J. C. Alexander (Eds.), *The new social theory reader* (2nd ed., pp. 80–86). Routledge.

Cuj, M., Grabinsky, L., & Yates-Doerr, E. (2021). Cultures of nutrition: Classification, food policy, and health. *Medical Anthropology, 40*(1), 79–97. https://doi.org/10.1080/01459740.2020.1826475

Farmer, P. (2004). An Anthropology of Structural Violence. *Current Anthropology*, *45*(3), 305–325. https://doi.org/10.1086/382250

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. Pantheon Books.

Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. University of California Press.

Government of Nepal (2018). Local Government Operation Act

Government of Nepal (2023), *Mult-sector Nutrition Plan (2023-2030):* National Planning Commission,

Government of Nepal. (2015). *The constitution of Nepal*. Nepal law commission. https://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/Constitution-of-Nepal.pdf

Harper, I. (2014). *Development and public health in the Himalaya: Reflections on healing in contemporary Nepal*. Routledge.

Haugaard, M. (2021). The four dimensions of power: conflict and democracy. *Journal of Political Power*, *14*(1), 153–175. https://doi.org/10.1080/2158379X.2021.1878411

Ji, R., & Cheng, Y. (2021). Thinking global health from the perspective of anthropology. *Global Health Research and Policy, 6(1)*, 47. https://doi.org/10.1186/s41256-021-00233-z

Ministry of Health and Population. (2019). *National health policy*. Government of Nepal.

Ministry of Health and Population. (2023). *Nepal health sector strategy implementation plan (2023–2030)*. Government of Nepal.

Ortner, S. B. (2006). *Anthropology and Social Theory: Culture, Power, and the Acting Subject*. Duke University Press.

Oxford Poverty & Human Development Initiative. (2013). *Nepal country briefing—Multidimensional poverty index data bank*. Oxford Poverty & Human Development Initiative, University of Oxford. https://ophi.org.uk/multidimensional-poverty-index/mpi-country-briefings/

Nepal Journal of Multidisciplinary Research (NJMR)
Vol. 8, No. 4, September 2025. Pages: 288-308
ISSN: 2645-8470 (Print), ISSN: 2705-4691 (Online)
DOI: 10.3126/njmr.v8i4.85648

Reckwitz, A. (2002). Toward a theory of social practices: A development in culturalist theorizing. *European Journal of Social Theory, 5*(2), 243–263. https://doi.org/10.1177/13684310222225432

Sen, A. (1981). *Poverty and famines: an essay on entitlement and deprivation*. Oxford university press.

Shah, S. K., Shetty, S. K., Singh, D. R., Mathias, J., Upadhaya, A., & Pandit, R. (2016). Prevalence of undernutrition among musahar children aged between 12 to 59 Months in urban Siraha district, Nepal. *MOJ Public Health*, *4*(5), https://doi.org/10.15406/mojph.2016.04.00093

Taylor, P. C., Tayler, E., & Luitel, B. C. (2012). Multi paradigmatic transformative research as/for teacher education: An integral perspective. In K. G. Tobin, B. J. Fraser, & C. McRobbie (Eds.), *Second international handbook of science education* (pp. 373–387). Springer.

Ulijaszek, S. (2024). Nutritional anthropology in the world. *Journal of Physiological Anthropology,* 43, 10. https://doi.org/10.1186/s40101-023-00345-0