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Taking Care of Children: Applying Anthropology in Maternal and Child Nutrition and Health

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Bringing anthropology to bear on programs and policies in nutrition and health requires the application of both theory and method. This paper describes several examples, drawing from my experiences related to infant and young child feeding and management of infectious disease in children. Part of the task is reframing the dominant biomedical and economic models to encompass the sociocultural contexts in which caregiving behaviors are embedded and elucidate their implications for the design and implementation of interventions. Another aspect is the development of tools that facilitate the use of anthropological methods in public health and nutrition. Thirdly, applying anthropological theories and methods to explicate the systems that deliver services and meaningful engagement with these systems so that the results can be used to improve nutrition and health interventions is another key focus. Finally, it is essential that we remain grounded in our anthropological roots and critically appraise and reappraise our working assumptions.

Key words: nutrition, parenting, intervention programs and policies, *actionable* knowledge

Introduction

When I was 15 an important photographic exhibit, titled the *Family of Man*, was shown in Minneapolis as part of a national tour (Steichen 1955). As the daughter of a professional photographer, there wasn't any question about my going to see it, although I also do not recall any discussion beforehand about its significance. Certainly my mother, the photographer, did not anticipate it would be a life-defining experience for me. It was. Like so many others who experienced that exhibit I was intensely moved, shaken, depressed, excited. The pictures have come back to haunt me again and again. But none more than the photograph by Consuelo Kanaga of an African-American mother and her children, titled *She is a Tree of Life to Them* <http://www.lacma.org/art/TreeofLife.aspx>. The woman, strong, wise, wary, and her children, the little girl, featureless, the little boy, anxious, curious: this photograph and its caption, which was taken from the Book of Proverbs, set my life course, although I did not realize it at the time.

Ten years later, as a graduate student in anthropology at the University of Minnesota, I was drawn to psychological anthropology (or "culture and personality" as it was then called) and to theoretical questions about personality formation, which leads one squarely into the study of child rearing or child caregiving practices. At the same time, in part because of my first field experience in a poverty-stricken community in northern Minnesota, I became increasingly more interested in nutrition and its role in health. I was unclear how these interests would be melded into work in applied anthropology, which was my fundamental motivation for becoming an anthropologist. My dissertation on the determinants of depression in adults in Northern Minnesota was undertaken

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within the context of a study designed to understand the use of public mental health services. It was in the right direction, but it didn't speak directly to the woman in the photograph.

In 1998, Robert and Beverly Hackenberg opened their Malinowski lecture with a fundamental question for applied anthropologists: "What is to be done?" (Hackenberg and Hackenberg 1999) They identify the question as the title of a famous essay by Lenin, published in 1901 and go on to pose an equally stunning query: "But what shall we do?" Transforming the collective challenge to a personal one, we each ask: "But what shall *I* do?"

In this presentation, I am going to sketch out the route I followed, guided by the goal of bringing anthropology to bear on activities to support and improve women's capacities to take care of their children. I didn't make this journey alone. Throughout my talk the use of "we" is literal, not royal.

There were two basic paths: (1) activities to affect the health systems with which women interact, with the goal of improving the quality of support these systems offer, and (2) activities aimed at giving women themselves *actionable* knowledge. I regard the latter as a form of empowerment, being thoroughly, if naively imbued, with the old adage that "knowledge is power." I'll start with a discussion of breastfeeding, go on to describe work on household management of infectious disease, and then come back to nutrition to discuss three issues: nutrition and child development, a nutrition and health project in Haiti, and finally some basic questions about interventions to improve young child feeding.

Breastfeeding

From the perspective of infant well-being the public health goal is to ensure that babies receive breastmilk. This remarkable substance cannot be gathered, or hunted, or grown. It cannot be purchased, at least not widely. Babies only get their mother's breastmilk if their mothers give it to them.

During the mid 1970s, I learned about the fundamental importance of breastfeeding for child survival and growth and gained an understanding about the biological and environmental basis for public health recommendations. My nutrition colleagues at the University of Connecticut were patient teachers and exciting collaborators on bio-cultural studies of breastfeeding.

As I had opportunities to engage in policy discussions about breastfeeding and observe programs, I was stunned by the shortcomings of the biomedical model that was being employed to promote it. The approach was prescriptive and presumed that once women understand that "breast is best," they would change their behavior.

From the perspective of applying anthropology with the aim of fostering social change, my own work in breastfeeding was focused on reframing the biomedical model. The goal was to demonstrate that breastfeeding was embedded in larger issues of women's roles, household economic organization, and cultural values and identify the implications of these issues for programs and policies (cf. Pelto 1981). The means to reach the goal were *elucidation*—research that involved a combination of field studies and analysis of ethnographic and epidemiological data—and *exposition*, particularly to other professionals and policymakers. The vehicles were papers, presentations, and committee work—all intended to communicate with nutrition and public health communities. Ethnographic examples were intended to persuade these professional communities not only about the empirical realities in which women were being exhorted to breastfeed, but also about the utility of adopting a more comprehensive, holistic, and contextual model than the dominant bio-medical model. The strategy was to draw on an underlying theory, which was not overtly explicated in terms of anthropological or psychological constructs, but which infused the discussion.

Now, some 30 years later, how much attention is given to the critical sociocultural and behavioral issues that affect breastfeeding? In many respects there has been significant progress. This is most apparent in improvements in the social conditions that support breastfeeding. The strongest examples are found in the progressive European countries where there have been very significant modifications to the social system in the form of extended maternity leave, family economic subsidies, and laws that protect women's job security, all of which have created economic environments that support caretaking of infants.

To a large extent these improvements can be attributed to the fact that a second, very powerful, model has entered public health. This model challenges the biomedical model and is gradually being integrated with it, in public health planning. It is the economic model, which rests on the fundamental concept of *homo economicus* (economic man). In essence, this model postulates that humans will make rational decisions to maximize what is in their perceived best interests, and that social interventions which make it attractive for them to select good behaviors, together with information about what is best, will lead to desirable behavior change.

There have also been serious efforts to change cultural values, and increases in breastfeeding rates reflect successes on this front. But there is still a long way to go, particularly in the United States where women are often obliged to retreat to the women's bathroom to feed their children. A few months ago a woman began to breastfeed her child on a plane before it took off. She was forced by a flight attendant to get off the plane on the grounds that she was making other passengers uncomfortable. Later, after she threatened to sue the airline, the president of the company apologized to her. This, too, can be interpreted as a sign of progress.

I learned a great deal from my work in the breastfeeding arena. I came to understand more about the empirical realities of infant care in the context of women's lives. I learned a lot about the dynamics of international organizations and committees, and the contexts of policymaking. I began to have a better understanding of the complexities of cross-disciplinary communication and the influence of social roles on the perspectives people bring to the conference table. My work on breastfeeding reinforced my belief in the importance of the

implicit and explicit theoretical models we bring to bear on a problem. When we work with other disciplines to design research or design programs and when we work with agencies and policymakers, an important aspect of what we bring to the table is our anthropological model, not just our methods. It needs to be given a rightful place alongside the models that dominate health interventions today—the biomedical model and the economic model.

The work on breastfeeding also led me to the conclusion that the strategy of persuasion through empirically-supported, theoretically-driven argument (elucidation and exposition) is important, but those who were directly involved, who participated, achieved more. Participation is essential if the goal is to bring about social and behavioral change. I am going to shift ground now to talk about my work as a participant at the World Health Organization (WHO), beginning with work on mother's (and father's and families') roles in caring for sick children.

Caring for Sick Children

You don't have to be a Jewish mother (or grandmother) to appreciate the importance of sick-child care to our very survival as a species. Although nature has a major role to play in recovery, and many illnesses are self-limiting, the application of preventive and curative care technologies (indigenous and biomedical) is still a major determinate of child survival from acute illness.

My involvement with childhood illness as a public health issue began in the arena of diarrhea management. The discovery that dehydration, a primary cause of death in children with diarrhea, could be prevented and treated with a simple inexpensive solution of electrolytes and sugar in water opened a new vista for preventing mortality. However, the promise of oral rehydration therapy could only be realized if families knew about the treatment and adopted it. Anthropologists began to play a role in advising health services and international agencies about how to reach families with actionable knowledge.

Programs were looking for a "quick fix" in the form of a "magic communication bullet." They asked us to find "cultural metaphors" for dehydration and oral rehydration solutions so that mothers would be motivated to use them. With the "culturally appropriate" message, everything would be fine. Of course it wasn't that simple. Our more enlightened medical colleagues appreciated the need to look more broadly at household management of childhood illness.

The anthropological studies that were undertaken during the 1980s provided opportunities to describe and understand household management, as well as to sensitize the public health and medical community to the complex realities of what happens in households when children are ill (eg. Bentley 1988). Studies that combined qualitative and quantitative analyses and presented results in formats that were familiar to physicians and epidemiologists helped to link ethnographic realities to biomedical concerns (Bentley et al. 1992). They provided a means of bridging communication barriers between professions.

A primary problem we all faced—anthropologists and public health professionals alike—was how to obtain context-specific information in a timely fashion and at low cost. Thanks to the exceptional vision and leadership of Dr. Michael Merson, who was then the director of the WHO division that dealt with diarrheal and respiratory infections in children, I had the opportunity to tackle this problem with sufficient resources to develop and test the feasibility of Focused Ethnographic Studies (FES) (Pelto and Gove 1992).

The topical area was acute respiratory infection, which, by the late 1980s, was replacing diarrhea worldwide as the number one cause of death in children, as mortality from diarrhea declined. The idea was to create a research protocol that focused on a pre-defined set of questions, which were described as "program managers questions." I was given wide leeway in defining the program manager questions, so the protocol included attention to all the aspects we felt were important. Ethnographic methods were used to collect data to answer the programme manager questions. The studies were followed by planning workshops to help national Acute Respiratory Control (ARC) programs translate the results into implementation plans. Each step in the process was supported by manuals, training workshops, and technical assistance as needed (Acute Respiratory Control Programme 1993a; Acute Respiratory Control Programme 1993b; Division for the Control of Diarrhoeal and Respiratory Infections 1995; Division of Child Health and Development 1997).

FES studies were conducted in many countries. Sometimes they were conducted by highly skilled anthropologists, including Joel Gittelsohn, Patricia Hudelson, Mark Nichter, and Ruth Wilson. Often they were conducted by individuals who did not have prior anthropological training. I was involved in more than 40 studies, and there were others I only learned about later. The results were used to adapt health worker training protocols, health worker counseling aids, and educational materials for families. Health workers were trained to use local emic concepts in medical consultations, to encourage positive traditional practices and to discourage negative ones.

One of the goals of the FES project was to provide caregivers with actionable knowledge. A modest indication of success on that score were the results from evaluation studies in Viet Nam and China, which indicated that mothers were more likely to recall, retain, and accept locally adapted advice (Dai, Pieche, and Pelto1997)

A second goal of the FES was to improve social interactions between health care providers and families. The hope was that giving practitioners information about local explanatory models, emic constructs and the rationales, and contexts for household behaviors would provide a better basis for communication. We did not have an opportunity to formally evaluate this goal, but one of the most gratifying experiences in my career relates to it. Two years after he had participated in an FES training workshop, and supervised

an ARI study, I met, again, an Iranian pediatrician who told me that conducting this study had completely changed the way he practiced medicine. He suggested that FES should be mandatory everywhere.

A third goal of the FES was to catalyze community actions to improve care of sick children. Planning workshops to review study results were intended to be vehicles for connecting the health services sector to other community institutions. We began to work on this in Pakistan (Pelto 1996) and Viet Nam, but the process required a great deal of facilitation, which WHO could not provide.

Unfortunately, the potential of the FES to affect ARI program actions was abruptly cut short by the disappearance of ARI programs themselves. No, deaths from pneumonia didn't disappear, only the way in which national health services were organized to address them. Vertical programs addressed to specific childhood illness came to a rapid halt when multilateral and bilateral funding agencies withdrew support for them in favor of more integrated approaches. In the wake of the overwhelming challenges, the new funding formulas created for national health ministries, not to mention WHO itself, the FES, as an institutional tool, slipped into quiet oblivion. However, the concept and the techniques have been adapted to other areas and uses, including nutrition (Blum 1997; Kuhnlein and Pelto 1997) and women's health.

I draw the following conclusions from the FES work:

1. It is feasible to apply ethnographic methods on a large scale in public health and nutrition programs because focused ethnography can be adapted for specific health problems.
2. It is inexpensive to use.
3. It does not require extensive training.
4. Data interpretation is accessible for program decision-makers.
5. There are some indications that applying ethnographic studies in programs makes a difference, but to date, there has been little systematic evaluation of impact.
6. Compared to biomedical interventions, it takes minimal financial and institutional resources to develop ethnographic tools and to sustain their use. Resources for the latter are in particularly short supply, and serious advocacy is essential if the potential is to be realized.

Nutrition and Child Development

Another line of work at WHO brings us back to infant and young child feeding and the role of caregiving in ensuring children's well-being. In the mid-1990s, an influential administrator at WHO, a pediatrician by training, insisted that activities in child health be expanded to include "child development." The operational meaning of child development was unclear, and some of my colleagues in the Division were up in arms about this unwarranted intrusion into the mission of saving children's lives. I saw this external demand as directly relevant to saving children's lives and as the opportunity to link nutrition and child development within a health context. With a miniscule budget, I turned to the nutrition division at Cornell University, and together we undertook a review of the scientific and programmatic literature on undernutrition and child development. We then brought in child development experts to help us expand the scope of the study, interpret the results, and frame recommendations. The result was an extensive and user-friendly report, titled "A Critical Link" (Pelto, Dicken, and Engle 1998).

The monograph concludes with a chapter of specific suggestions for activities to support child development within nutrition and health contexts. These suggestions cover the range from policy actions to program delivery. The review was published by WHO and taken up by both UNICEF and the World Bank. Thousands of copies were distributed, and the informal feedback was very positive. I expect it educated its readers about the relationship between child feeding and child development. However, to date, progress in integrating child development interventions into health services has been slow.

Nutrition and Health Interventions

Integrating nutrition into child health services is evolving rapidly. Many factors, including effective advocacy in international agencies and large NGOs, have contributed to increasing recognition of its importance for child survival and child health. A major challenge for program effectiveness will be finding ways to improve interactions between health workers and caregivers as these relate to nutrition advice given in the context of clinic visits for both well-child and sick-child care.

The Haiti Project

When I resumed an academic career, moving to the Division of Nutritional Sciences at Cornell, a project in Haiti provided the opportunity to apply anthropological methods and theories, not only in support of improving outcomes for children, but also to support the operation of the delivery system for the intervention. With colleagues at the International Food Policy Research Institute (IFPRI), we developed a large-scale field trial in rural Haiti to test the effectiveness of two different models of preventing malnutrition within a health program, which was organized and delivered by World Vision. Both models provided food rations and healthcare to beneficiaries. The field research component began in 2001 and was completed in 2006.

The basic structure of the intervention delivery system was already fixed because it was to operate within the pre-existing World Vision health service system and food supplement guidelines. We were responsible for designing the content and the implementation plan of the intervention. In the formative research, we explored issues of household organization and management of childcare in relation to household economic strategies and women's health, as well as the more usual collection of data on beliefs and practices related to nutrition and health. Based on my earlier program experiences, I felt it was important to have a systematic plan

for "crossing the bridge" from formative research to program planning. Consequently, we created a set of data matrices to facilitate the process of developing, with World Vision administrators and technical supervisors, the scope and content of the interventions. In a planning workshop, the matrices were used to identify goals for specific behavior change both for caregivers and front line workers. To the fullest extent possible, we built the curriculum for "behavior change communication," delivered through mother's clubs and at other venues, on local conditions, beliefs, and values. The goal was to create an environment of actionable knowledge.

An important feature of the study plan was the systematic application of "program theory." This is a concept that comes from evaluation research. It requires the explicit specification of the pathways through which an intervention is expected to have its impacts, and leads to iterative investigation of the delivery process. Consequently, after the initial implementation, we conducted two intermediate "operations research" studies that examined the delivery process from multiple perspectives—from program administrators to front-line workers and community volunteers to program beneficiaries. Because of the collaborative relationship with World Vision, we were able to work with them to address some of the problems these studies revealed. From the research perspective, ensuring that data were gathered from multiple stakeholders provides us with a rich database from which we can derive new insights about program delivery processes.

The project is now completed, and the first papers are being published (Ruel et al. 2008). We have a clear answer to the basic question it was designed to answer. A program based on preventing malnutrition through universal targeting is much more effective in reducing the prevalence of malnutrition in the community than is one based on curing children once they become malnourished. In the coming years, we will share the many other findings and insights the research has made possible, as well as engage in advocacy for a community-based, food-supported approach to the prevention of malnutrition in early childhood.

Responsive Parenting

Finally, I want to briefly discuss another related research direction that emerged from the Critical Link exercise. This is the role of "responsivity" in child feeding, particularly during the critical period of complementary feeding. "Complementary feeding" refers to the period that begins when breastmilk alone is not enough to sustain child growth and ends when children are fully fed from the family diet and are no longer receiving breastmilk and other special foods. (We used to refer to weaning foods and the weaning period but these have been replaced by the concept of "complementary feeding" in order to highlight the idea that these foods are complements to breastmilk.)

From the framework of developmental psychology, responsive parenting draws attention to two key features: (1) caregiving that is attuned to children's changing developmental needs; and (2) caregiver/child engagement in mutually reinforcing actions.

At Cornell, we conducted an analysis of cultural and social-behavioral factors in complementary feeding, commissioned for a WHO workshop. In this review (Pelto, Levitt, and Thairu 2003), we examined the concept of responsivity in complementary feeding more operationally. Using findings from nutrition research and ethnographic studies, we explored various components of complementary feeding, moving beyond a biomedical emphasis on *what* is being fed to consider other aspects: *how* foods are given, *when* they are given, *where* they given, and *who* is involved in feeding. From the child's perspective, these aspects—how, when, who, where—have nutritional consequences because they affect what the child ingests. They have other consequences as well because they define the character of daily life experience. In the caregiver, the behaviors reflect responsivity to the child's biological and emotional needs.

It was difficult to find data on these aspects of infant feeding, which is hardly surprising given the general lack of awareness about their potential importance. However, what we did find is disturbing. Across the globe, and in very different types of social settings, whether one looks at them in relation to the genesis of undernutrition or obesity, many common patterns of complementary feeding practices are less than ideal from the perspective of promoting the physical and psychological well-being of children. At one end of the continuum are highly controlling feeding practices, which essentially force the child, physically or emotionally, into accepting food. At the other are laissez-faire feeding practices in which children are expected to feed themselves from a very early age (Bich Ha et al. 2002)

An examination of specifics of the where, when, who, and how of infant and young child feeding is an analysis of one of the key behavioral components of caregiving, specifics that affect how well a child will grow, develop, and resist infection. Underlying this component, and other aspects of caregiving, is another dimension of causality—the psycho-social system that we refer to under the rubric of cultural values, attitudes, and expectations. This underlying system includes basic concepts and orientations that affect how individuals interact with others, conceptions related to security and fear, empathy, and the ability to see things from the perspective of another, ideas about freedom and responsibility, and so on.

For any given individual, the underlying psycho-social dimension is formed, in part, by shared expectations and values that are acquired because one is a member of a particular social/cultural group. Included in this system are concepts about parenting that affect multiple aspects of caregiving. For example, in Euro-American culture, the adage "spare the rod and spoil the child" reflects an underlying value orientation that is manifested in over controlling behaviors, including feeding and care in infancy and early childhood. Similarly, in many cultures, there are strong concerns about preparing a child to be independent and capable of withstanding the

hardships that life will deliver. These values, too, permeate caregiving beginning in infancy, and they can lead to lack of understanding of children's needs and, therefore, to lack of attentiveness to those needs.

In addition to the shared cultural orientation, there is also a great deal of intra-cultural diversity in the psycho-social value system, which comes about as a consequence of individual factors, including state of health, history of physical or psychological abuse, inborn temperament, and so on.

Does this underlying psycho-social system matter for interventions to improve nutrition and health of children? To date, it has received very little attention either from researchers or from programs. In earlier decades, some anthropologists—Irving Hallowell, John Whiting, Bea Whiting, Margaret Mead, and others—focused on understanding how child rearing practices related to personality development and psychological well-being in specific cultural contexts. This is very close to the social-emotional aspects of parenting I am drawing attention to here, but with an important difference: they did not extend their inquiries to examine the implications for actions, for interventions to improve child well-being. It is time to do that. We need to ask:

1. Is the present intervention focus on behavior change adequate, or is it necessary to address the underlying concepts (values and value conflicts) that underlie behaviors?
2. If responsive infant feeding and care practices make a difference for child health, how can it be motivated in the various different contexts and constraints within which caregiving occurs?
3. Most importantly, how can nutrition and health programs develop systems to provide social-emotional support for responsive parenting that are feasible for implementation on a public health scale?

I think the answer to the first question is yes. The second leads us to the importance of laying out a research agenda of elucidation and exposition. For anthropologists to play a role in relation to the third question will require committed participation.

To conclude, here are a few brief comments about areas of progress and areas of concern:

On Progress:

1. In many countries, efforts to improve caregiving for children are increasingly imbedded in social support programs to reduce economic barriers to food and healthcare. Without such support, activities to change the culture of caregiving through educational interventions are ineffective at best and unethical at worst because families have little opportunity to act on new knowledge.
2. Increasingly educational actions are directed not only to caregivers, but also to improving the capacity of providers (community programs and front line workers) to impart knowledge using better communication skills and in an interactional fashion that engages rather than simply instructs.
3. Increasingly, the content of education for caregiving is situationally and culturally appropriate, making it more actionable within the cultural context and constraints imposed by economic, social, and environment conditions.

But we have a long way to go:

1. Economic and social barriers that prevent families from providing their young children with adequate care are still immense. Improving the larger economic-legal-political systems is imperative, as is the need to find means for sustaining the progress that has been made in a world of increasing disparities between rich and poor, and in which global pressures on scarce resources are increasing.
2. Service delivery systems—from top management down to the local level, often including the front line workers who reflect the attitudes of their organizations—still tend to operate from a perspective of social superiority. Health sector personnel do not typically see themselves as "servants of society." The concept that it is their responsibility to ensure that families understand how to take better care of their children or that failures in family care reflect, to some degree, a failure on their part, would strike many of them as bizarre.
3. Although I have used the term "families" in these summary points, in reality, educational/cultural change interventions in nutrition and health are still directed almost exclusively to mothers. They are not grounded in the social realities of family organization of care. This is inefficient and wasteful. It is also a source of conflict within families as mothers are exposed to new ideas that run counter to the beliefs of other family members, particularly their own mothers and mothers-in-law who are often intimately involved in child care. This conflict and its effects on care have not been adequately investigated.
4. At present, caregiving interventions are aimed almost exclusively at improving behaviors. We even call it "*behavior* change communication." When we unpack the underlying theoretical structure on which interventions to improve caregiving are based, we find the following: a model in which inputs to knowledge are presumed to be actionable *if* they are persuasive (i.e., culturally acceptable) and *if* the household circumstances—economic security, food security, access to appropriate foods and healthcare, on one hand, and social support on the other—are in place. What is generally missing from this model—and from the interventions that are built on this model—is the social-emotional values/attitudes/expectations dimension of health and nutrition parenting.

Many of us, and I count myself among the guilty, have left this dimension out of serious consideration in our working models. It is time to correct that omission. In my view, this is the next frontier for research and action that is intended to improve the well-being of children.

To conclude, I want to share with you the full verse of the proverb from which Kanaga took the title for her picture *She is a Tree of Life to Them*:

> Happy is the man who finds wisdom, and the man who obtains understanding…. She is a tree of life to them who lay hold of her: and happy are all who retain her. The Lord by wisdom founded the earth; by understanding he founded the heavens. By his knowledge the depths are broken up, and the clouds drop down the dew.

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