

**CONSUMING EXPECTATIONS: AN EXPLORATION OF FOODWAYS IN
RELATION TO HEALTH AND MATERNITY AMONG NEPALIS LIVING IN
NORWAY**

A thesis submitted for the degree of Doctor of Philosophy

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A Note on Terminology

In this thesis there are several terms that recur throughout and require suitable definition, namely ‘foodways’, ‘Nepali’, ‘immigrant’/‘migrant’ and ‘South Asian’.

‘Foodways’, a term commonly used within anthropological and sociological discourse on food and eating, can be defined as “the eating habits and culinary practices of a people, region or historical setting” (Merriam-Webster 2016a), and it is with this meaning that I use it in this study.

‘Nepali’ is used as both noun and adjective – to describe the people (‘Nepali’ in singular/ ‘Nepalis’ as plural) and their habits and practices that form the basis of this research. Both ‘Nepali’ and ‘Nepalese’ are employed within anthropological writing and were used by my research participants, some favouring the former, others the latter.¹ While I regard them as synonyms, for consistency and to avoid unnecessary confusion, unless quoting one of my respondents directly, I use ‘Nepali’. In either case, it applies a single term to a very diverse people. In Nepal there is population of nearly 30 million,² comprising over 100 different caste and ethnic groups,³ many regionally-specific (Middleton & Schneiderman 2008). The Hindu Baahuns, Chhetris and Dalits form the majority, yet other ethnic groups including the Newars, Gurung, Sherpa, Tibetans, Tamang and Tharu, to name but a few and although sometimes relatively small in number, are acknowledged as distinct (Gellner et al. 1997). Nepalis who have come to Norway to live and work to some degree reflect this; most of those I spoke with, for example, identified themselves as being either of the Baahun or Chhetri castes, yet there were others who described themselves as Newar or Gurung. It follows that beliefs and practises among Nepalis are many and varied. To speak of a single ‘Nepali culture’ in relation to foodways and health (let alone in relation to pregnancy and postnatally) is, therefore, impossible. Nevertheless, as will be seen, certain patterns and practices were shared by several of the Nepalis I encountered, albeit often with personalised elements or nuances. And so, when

¹ I checked with a principal Nepali contact about this, whether one was more correct than the other, and he told me that both were fine as far as he knew although he himself tended to use the term ‘Nepali’ to refer to the language and ‘Nepalese’ otherwise.

² Total population of Nepal in 2015, as published by the World Bank, was 28,513,700 (World Bank 2016a).

³ For simplicity the term ‘ethnic’ is used throughout this thesis all the while acknowledging its potential to essentialise a fluid state of affairs, the definition of which in any one case may be multiple and contested, and in anthropological scholarship has tended to be discussed in terms of ethnicity (Gellner 1997; Hylland Eriksen 2001).

comparing their health-related foodways to Norwegian (or other, for example Pakistani) cases, the ascription of ‘Nepali’ is used yet in a qualified way, to refer only to those people I worked with and all the while accepting that it remains a generalisation.

Unless otherwise stated, the term ‘immigrant’ is used throughout this work in very simple terms to refer to persons of non-Norwegian ethnic origin, now living in Norway, usually those who came to the country as children (settling there with their parents or families) or who have arrived as adults. Although, according to dictionary terms, to immigrate is “to enter and usually become established; *especially*: to come into a country of which one is not a native for permanent residence” (Merriam-Webster 2016b – original emphasis retained), several of my informants were uncertain whether or not they would remain in Norway long-term, so could arguably be more correctly termed as ‘migrants’.⁴ But as very few I spoke with expressed concrete plans for when they would leave – several saying that if they got a good job in Norway they would stay, ‘perhaps’ returning to Nepal when they retired – it seems unnecessarily confusing to the reader to try to apply both terms within this study.

‘South Asian’ is a geographically-convenient categorisation, used to identify immigrants from Pakistan, Sri Lanka and India, Nepal, Bangladesh and Bhutan. As a term, it clearly groups populations expressing considerably heterogeneity under a single heading. Despite its evident lack of specificity, it has considerable currency within biomedical and public health accounts and given that my work relates to these directly, I do at times use it. However, as will be seen, I am outspoken about the term’s problematic nature – principally its homogenising potential to efface significant differences and thus generate misleading conclusions.

Writing of non-English words and terms

All Nepali words are written in simple italics, e.g. *jwano* (thyme seed, in Nepali).

The Norwegian names of formal institutions and websites, such as Helsedirektorat (The Ministry of Health), Helsenorge (the main health information website), the Folkehelseinstituttet (Norwegian Institute of Public Health), Matilsynet (Food Standards Authority), Matportalen (the main food information website) and Statistisk sentralbyrå or SSB (Norwegian Central Statistics Bureau) – all of which occur frequently throughout this study – appear as written. All other Norwegian words or phrases, however, appear in italics, and if the meaning is not already

⁴ To migrate is defined as “to move from one country or place to live or work in another” (Merriam-Webster 2016c).

explained in the main text a direct translation follows in brackets. The language identifier ‘Nor:’ is used to differentiate it from Nepali terms, e.g. *svangerskap* (Nor: pregnancy).

Otherwise, one specifically Hindi term also features in the text. There the alternative language identifier, ‘Hin:’ is used to distinguish it from Norwegian or Nepali terms, i.e. *jalebi* (Hin: a deep-fried sweet pastry).

There are, in addition, occasional instances where italics are also used to imply emphasis of English words. These cases are relatively few, however, and where they do occur, the meaning should be obvious.

Abstract

This thesis focuses on Nepalis living in Oslo and Ås, Norway, and ethnographically explores their food perceptions, habits and practices in relation to health and maternal health. With pre-existing experience of both biomedical and other understandings of health and wellbeing, the majority of my respondents could and did move between paradigms, on an individual basis deciding which to apply and when. Consequently, several demonstrated certain reasoned divergences from Norwegian state-endorsed dietary norms and expectations; differences that were, however, not simply reducible to ‘culture’. ‘Culture’ is shown here to be a favoured strategy of explanation within Norwegian public health research, which has dominated state health perceptions of all South Asians.

Overall, four key arguments are advanced. Firstly, the need to disaggregate the category of ‘South Asian’, currently readily employed within public health research and policies worldwide to describe and problematise the foodways of highly diverse diaspora populations. The middle-class status of my Nepali respondents is delineated as a central example exposing the inaccuracy of such a homogenising generalisation. Secondly, that despite the hegemony of biomedical models of nutrition within health and ante-/postnatal wellbeing in Norway, my interlocutors moved between these and other ideas and practices of health and wellbeing. Describing their dietary habits and practices makes plain the narrowness of applying purely biomedically-predicated thinking to understanding these Nepalis’ foodways. Thirdly, that in ante-/postnatal care the biomedical model overprivileges the individual mother’s responsibility for her own health in order to benefit her child, ignoring the potential for alternative distributions of responsibility for, as well as emphasis on, both offspring *and* mother: the Nepalis I encountered showed a notable commitment to the mother’s wellbeing and also sense of pregnancy and postnatal care as a collective enterprise, relationally shaped. Fourthly, my Nepali respondents’ accounts provide a useful example demonstrating limitations to the perceived authority of Norwegian state advice on health in general. Well-informed and often highly educated, these Nepalis engaged only selectively with the state-endorsed guidance and services, instead drawing on other (re)sources – Nepali family and friends especially – to maintain health and wellbeing.

Chapter 1 – Introduction

It was late on a snowy January afternoon in Oslo, Norway. In a well-appointed third-floor apartment, in one of the city's outer suburbs, I was sitting with eleven Nepali women around a large dining table. The sound of children playing in the adjacent rooms filtered in, accompanied by their occasional visits to request a drink or something to eat. Empty plates in front of us bore traces of the rice, two vegetable curries, called *tarkari*, and fresh *achaar*, or pickles, which we had all been enjoying. There were bones from the fragrantly-spiced, fried chicken on the plates of those who ate meat. When Indira, our hostess, together with a couple of her friends went into the kitchen to prepare *dudh chiyaa*, the Nepali name for sweet, spiced milk tea, our discussion turned to the importance of *ghee*, or clarified butter, after the birth of a child. Annie, who worked as a senior nurse, took up the story: some years earlier, there was a Nepali doctor she knew, living in the northern Norwegian city of Tromsø. Married to another Nepali, she had recently given birth. "Their son was ten days old and they were waiting for *ghee* to arrive from Nepal, but none had come", Annie explained, the woman having previously arranged that some be sent to her by relations. Knowing that there was "cow *ghee*" available to buy in Oslo, Annie bought "four litres, also some *jwano* (thyme seed) and sent it all the way to her. They [the couple] were really thankful for that". "This is how important eating *ghee* after birth is for Nepalese women", Annie then said, addressing me directly. Several other of the women murmured or nodded in agreement. "She was missing it", Indira commented, now back at the table, offering steaming cups of tea that she knew I liked very much. "It was like a *nødt* [Nor: emergency] situation", she added grinning, causing the rest of the gathering to erupt into laughter. "So, it was like 'emergency *ghee*'?" I suggested, half-checking, half-joining in with the light-hearted atmosphere. "Yes, emergency *ghee*", both Annie and Indira responded, laughing and provoking further expressions of mirth amidst the assembled company.

This moment during my fieldwork goes to the heart of this thesis. Based on long-term ethnographic fieldwork, including in-depth engagement with Norwegian public health sources and resources, it explores the following research questions: How do dietary habits and practices among a specific group of middle-class South Asians living in and around Oslo relate to their perceptions of health and wellbeing? And especially, in relation to pregnancy and the postnatal period? I will address both the perceptions of the Nepalis I worked with, as well as those of the host nation, Norway, as communicated through state-endorsed guidance as well as public health research and publications. In particular, I explore Nepali ante- and postnatal dietary habits and practices while living and having children in Norway, and Norwegian state guidance on food matters during pregnancy and following childbirth. My work advances four key arguments. Firstly, the need to disaggregate the category of 'South Asian', currently readily employed

within public health research and policies worldwide to describe and problematise the dietary habits and practices of a group of highly diverse diaspora populations. Secondly, that despite the hegemony of biomedical models of nutrition in relation to health and ante- and postnatal wellbeing in Norway, Nepalis (as indeed most people in general) move between these and other notions and practices of health and wellbeing, and this needs to be recognised and better understood. Thirdly, that in ante- and postnatal care, the biomedical model overprivileges the individual mother's responsibility for her own health for the sake of her child at the expense of potentially more collective expressions of responsibility for, as well as emphases on, the wellbeing of both mother and infant. And fourthly and finally, that there is a need to look beyond any state claims or assumptions to be a key source of authority and advice on health in general.

Some background

Researching dietary habits and practices is a complex undertaking. Various methodological, analytical and theoretical approaches have been used within anthropological and social sciences enquiries into foodways (Caplan 1997; Counihan & Van Esterik 2012). These range from structuralist (Lévi-Strauss 1970), symbolic (Douglas 1966), historical/materialist (Mintz 1985; Goody 1982), philosophical and Foucauldian (Coveney 2006), sociological/gender-based (Murcott 1983, 1993, 1995), to those in critical medical anthropology (Chen 2009). Each analytical lens and theoretical framework brings with it alternative and novel ways to investigate, the mixture of methodologies often viewed as an advantage (Counihan & Van Esterik 2012).

Anthropological and sociological literature suggests, moreover, that eating food positions people as agents, exercising volition and intention, as well as social actors using what, when and how we eat to construct and perform all manner of social relationships and interactions (Caplan 1997; Douglas 1966; Goody 1982; Helman 2007; Messer 1984; Mintz & Dubois 2002; Murcott 1996). If we are to understand the foodways of individuals or groups of people in a certain setting, the historical, social and cultural context and the multiple meanings ascribed to food must all be taken into account (Caplan 1997). At the same time food is physically transformative, maintaining and restoring corporeal materiality and, in the case of pregnancy, enabling the formation of a new human being. Again, sociological and anthropological studies have explored these aspects. Fischler (1988), for example, developed the concept of 'incorporation' whereby ingested food has physiological as well as ideological functions, transferring culturally-ascribed values to the consumer while at the same time assimilating them into the particular culinary system and culture. Along similar lines, Carsten's work in Malaysia (1997) highlighted the importance of feeding infants and children with foods intimately

associated with their natal home in creating a person both physically and socially part of that household.

Adjustments that people make to what they eat and drink are also often strategies towards trying to maintain health and to avoid or overcome illness. As anthropologists and sociologists have shown (see, for example: Caplan 2002; Donner 2008b; Douglas 1966; Harbottle 2004; Khare 1986; Nichter 1986; Ray 2004), in societies around the world how people tend to decide on which changes to make is informed by numerous factors, including personal experience, family and other social influences, as well as the medical systems one is familiar with or becomes exposed to.

Particularly interesting instances of food choices occur during pregnancy, when many women make temporary, and in many cases unprecedented changes, to their non-pregnant lives. When pregnant, women the world over tend to pay extra attention to what they eat, as do the people and institutional ‘bodies’ – family, health care services and others – that surround them. In much of the developed and developing world, biomedicine has achieved hegemonic status, and the management of pregnancy and childbirth has become part of its remit. Based on the same Western scientific paradigm as biomedicine, nutritional information is made available to expectant mothers as part of this assumed area of competence and jurisdiction. Pregnant women living, or coming to live, in countries where biomedicine is the prevailing medical system within the dominant culture are therefore usually exposed to state-sponsored guidelines and recommendations as well as numerous media sources that all employ a rhetoric of biomedical health and nutritional ideas. Equally, if not more important, family and friends, as well as pre-existing ideas and practices of the women when coming from other places, are crucial. What to eat and what not to eat is a key concern.

In Norway we find a pervasive biomedical account of nutrition that surrounds most mothers-to-be. In addition to high educational levels, strong economic means and free medical services during this phase of their lives, the widespread biomedical and nutritional information appears to have positive consequences for women and their children: maternal and infant mortality rates are almost negligible.⁵ More generally, a comprehensive welfare system provides near-universal

⁵ In Norway, between 2011–2015 the maternal mortality rate, defined as “the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births”, was 5; meanwhile, the infant mortality rate there, defined as “the number of infants dying before reaching one year of age, per 1,000 live births in a given year”, was 2 (World Bank 2016b). To put this into perspective, for that same period in Nepal, the maternal mortality ratio was 258 (World Bank 2015) and the infant mortality rate 29 (World Bank 2016b).

state-sponsored health- and childcare and there are generous parental allowances (Angell 2008; NAV 2013).

The discovery in 1969 of massive oil and natural gas reserves in Norway's North Sea territories resulted in the nation becoming extremely wealthy and economically powerful (Abrahamsen 2008). The newfound mineral wealth led to a labour deficit so foreign guest workers were invited, coming mainly from Pakistan and India (Maagerø & Simonsen 2008). By 1975, however, the migrant inflow was stemmed by the government due to immigration levels being perceived excessive and it remains relatively low by European standards (Gullestad 2002). Nonetheless, asylum seekers, family members of those already in Norway and refugees are all still generally entitled to apply for visas. Given Norway's strong international profile linked to humanitarian policies overseas, while at home remaining a rich and stable democracy upholding of ostensibly egalitarian social values (Gullestad 1989, 2002; Repstad 2008), the country remains a popular destination for would-be immigrants.

There is a well-established presence of South Asians now living in Norway, with a majority originating from Pakistan, Sri Lanka and India, and a minority from Nepal, Bangladesh and Bhutan, and increasing numbers of their descendants are being born and raised in the country. Although Nepalis have been coming to Norway for several decades, usually as part of higher education courses, compared with other South Asian groups present their resident population is small, currently around 2000 (SSB 2016a). Over the past decade the dietary habits and practices of South Asian immigrants have become an evident source of concern to Norwegian health authorities, high levels of obesity, diabetes and coronary heart disease identified among Pakistanis especially, couched firmly within biomedical nutrition terms that foreground immigrant foodways as part of the cause (Holmboe-Otteson & Wandel 2012; Råberg Kjøllestad et al. 2011; Mellin-Olsen & Wandel 2005; Wandel et al. 2008). The health of pregnant immigrants to Norway has also come under recent attention (Garnweidner 2013). Biomedical research had indicated that certain women, especially those from African and Asian groups, are at greater risk of developing gestational diabetes and of becoming overweight, both a potential hazard to the expectant mother and her child. Consequently, Garnweidner sought to identify possible barriers to communication about healthy diet in the antenatal setting.



Fig. 1. Map of Norway (Google maps 2016a)

Having previous experience of foodways- and maternal health-related research in Nepal (Vidnes 2011, 2015), I was interested to find out about how perceptions surrounding diet, health and maternity combined among Nepali women (and their families) who reside in Norway. As mentioned, there are relatively few Nepalis in Norway and I became aware of only one other piece of research relating to Nepalis living there, namely a Master's thesis also on foodways (Malla 2005). Based firmly within the discipline of nutritional sciences and concentrating on the usual diet of its research participants, it focused on the change in pattern of meals as well as their composition, drawing conclusions that related findings in largely nutrition-based terms. Malla's work offers useful comparative examples and structural support to my research but does not explore perceptions of health more widely nor does it look at specific states such as pregnancy or the antenatal period.

A further reason to consider Nepali immigrants is as a means of disaggregating the category ‘South Asian’, currently used by official bodies (public health institutions, for example) to describe people from the Indian sub-continent, especially in the context of immigration and health. To be fair there have been relatively recent attempts within Norway to draw attention to the enormous degree of diversity in dietary and health-related habits and practices between immigrant groups, thus highlighting the inaccuracies that can emerge if health authorities act on too broader generalisations (Helsedirektorat 2011; Kumar & Viken 2010); the *Nasjonale kompetanseenhet for minoritetshelse* (NAKMI) (Nor: National Competence Centre for Minority Health) has made a particular effort in this regard. Nevertheless, in Norway as well as internationally, people categorised under the (very generalising) rubric of ‘South Asian’ have been considered to be at greater risk of developing certain chronic conditions, and especially after they have moved to these more wealthy countries. Diet and the attendant changes made by these immigrants upon their moving are regarded as a principal reason for these negative health outcomes (Holmboe-Otteson & Wandel 2012). Yet within South Asia, food-related habits and practices vary enormously within and between nations, as do health beliefs in relation to diet. While there is considerable congruence and overlap in principal ingredients (rice, pulses, vegetables) as well as knowledge of certain medical systems in addition to biomedicine (Ayurveda, for example), there are also differences. Thus by looking more into localised particularities, in this case into some of the habits and practices and perceptions regarding foodways, wellbeing and pregnancy of the small but growing Nepali population in Norway, I hope also to add nuance to existing accounts of South Asian diaspora foodways there.

Major themes

The encounters between the overwhelmingly biomedically-predicated dietary information present in Norway and people with lived experience of considerably different ethnic, cultural and social background raise several important questions to medical and social anthropologists: How do diverse understandings of food’s inter-relationship with health, notably during pregnancy, co-exist? How do women and their families use food to achieve wellbeing? How is the highly individualised perception of health present in Norway, evident in the emphasis on personal responsibility for making ‘healthy’ food choices generally (Middelthon 2009), and in pregnancy for following certain foodways (Helsedirektorat 2009; Helsenorge 2014b; Matportalen 2015a), met with by people from abroad coming to live there? And to what extent does the caste or the class composition of an immigrant group impact on their integration and interaction with the host nation and its institutions?

As already mentioned, the specific interest in Nepali immigrants stems from pre-existing experience during my Master’s degree, where I undertook fieldwork in a Gurung village in

central Nepal. There the focus was more squarely on maternal health (Vidnes 2011, 2015) yet I also learned more about the ways in which the villagers related food and health, not least in relation to pregnancy. Subsequently, having moved to Norway, I experienced first-hand surprisingly different dietary habits and practices from my own (English) ones. Coming from the UK, I was used to a wide range of readily available foods – fruit, vegetables, pulses, grains, vegetarian options (tofu, for example), spices and condiments – and international culinary traditions to draw on, as well as considerable diversity among what friends, family members and colleagues might eat according to personal tastes. Yet in Norway I encountered a markedly narrower range of foodstuffs and styles available, and among Norwegians more conservative food habits in general; the price of food was also much higher than in the UK. As a result, it took me some time to find ways to eat ‘well’ in Norway, leading me to reflect on how it must be for immigrants coming from further afield, and places – such as Nepal – where foodways were even less similar and perhaps more specifically linked to ideas of health. During this time, I was also trying to start a family and hence became increasingly aware of and exposed to antenatal dietary advice available in Norway. The research that has led to this thesis was thus provoked by my previous research and own personal experiences. What does it mean for Nepalis eat to ‘well’ in Norway – in terms of general health, and in particular during (and just after) pregnancy?

Nutrition: the biomedicalisation of food and dominance of this model in Norway

Eating as a principal means to maintain or recover health has been a strategy used for well over two thousand years in many places (Chen 2009). Documentary evidence of food being used for medicinal purposes, usually by the general populace, is amply evident in the Hippocratic writings from Ancient Greece, and also in ancient Chinese medical and dietary texts as well as those from South Asia (notably from the healing tradition of Ayurveda) (ibid). Post-Enlightenment developments in science, trade, industry and biomedicine, alongside strategies to manage growing populations as well as certain ongoing links between spiritual (mainly 19th century Christian reformists) and bodily health, all contributed to the emergence of a discourse of nutrition, and its application to food (Coveney 2006). This was a narrowed-down view, predicated on Western scientific theory and concepts, which created a specialist body of knowledge whereby foodstuffs were reframed as variable combinations of potential nutrients (proteins, carbohydrates, fats, vitamins etc.). In the right balance these nutrient elements could thus retain or restore corporeal form and function, hence reducing health to a state of physical integrity (Chen 2009; Coveney 2006). The continued dominance of biomedicine, and nutrition allied to it, has within Western culture resulted in innumerable nutrients being implicated in disease processes, then identified in foods from which they are subsequently isolated to become medicine or supplements intended to be used as treatment, preferably preventatively so (Chen

2009). In other words, from ancient understandings of food as medicine, through the paradigm of nutrition, medicine as food is now being created. However, as nutritional research continues, the recommendations that result from it remain in a near constant state of revision – new findings at times contradicting previously respected positions. For example, using the term ‘nutritionism’ to underscore the ideological nature of this scientific turn in understandings of food, Pollan (2008) offers a concise but illuminating account of the particularly convoluted health status of dietary fats within nutrition discourse over the past century.

Coveney (2006) has argued that present-day practices of nutrition as well as the modern subject are both “target and effects” of a particular system of thought (ibid: 2). Deriving his position extensively from the work of Foucault, in particular the concepts of technologies of power and technologies of the self (Foucault 1991a), Coveney explained how “the modern subject of food choice” is formed through their relationship with existing knowledge and power structures: “the way in which nutritional knowledge is made available through practices and techniques (such as surveys, examinations, comparisons and normalisations) as well as the way in which this produces new knowledges, problems, concerns and strategies for correction” (ibid: 9). He also paid close attention, however, to the way people are actively involved in constituting themselves through socially and culturally patterned practices of self-regulation (technologies of the self) (ibid: 11). Foucault’s concept of ‘governmentality’ thus featured strongly, used to depict the existing discourse of nutrition as following the trajectory of increasingly sophisticated attempts to govern groups of “men and things” (Foucault 1991a: 93 – 94), which the French philosopher identified as having emerged from Europe during the 16th century, and that were necessary for the formation of modern states. Coveney (2006) takes this concept forward, showing how methods and theories to better know and manage people (population sciences, statistical surveys, public health programmes) were developed and mobilised, becoming ‘technologies of power’ that could reframe food within scientific, rational terms; yet, at the same time, ‘technologies of the self’ were also present, as individuals sought to know and act on themselves – a government of the self – which required discipline and training. Within this, a new morality of food and eating, related to consumers’ dietary choices, is delineated – ‘right’ foods that are ‘good’ to eat – a concept that is well-established within Norwegian society (Middelthon 2009).

Coveney’s work is therefore significant to my own for demonstrating, through a Foucauldian reading, that contemporary discourses on nutrition are historically contingent, and that modern-day consumers of food have been produced by the interplay of particular forces at particular times. It compels me, when looking at the relationship between structure (be it state medicine, family, community and alternative medical paradigms etc.) and agency, to also take sufficient

heed of the specific cultural-historical context in which the actors – in this case middle-class Nepalis, living in Norway – are situated. Furthermore, given that I have examined not only how informants formulated their maternity-related foodways, but also how they then negotiated between these and state-endorsed guidance, a reading of nutrition in terms of governmentality, technologies of power and technologies of the self is also relevant. The relationship between my own work and that of Foucault, Coveney and Middelthun is discussed further in Chapter 5.

Existing anthropological research in contemporary Norwegian society delineates a pronounced medicalisation and instrumentalisation of food in the service of a biomedical account of health (Middelthun 2009). Middelthun's cogent analysis of the "pharmacologization of food" in Norway identifies a clear dichotomisation of food into either 'healthy' or 'unhealthy', which thus encodes a morality into food choice ('good' or 'bad') that can be used to hold individuals to account for their health (or illness) according to the dietary selections they made or make (ibid: 209, 221 – 22). This perspective is very evident in concerns recently expressed by Norwegian public health institutions and researchers about the diets of South Asians living in Oslo (FHI 2005, 2015; Holmboe-Otteson & Wandel 2012; Mellin-Olsen & Wandel 2005; Råberg Kjøllestad et al. 2011; Wandel et al. 2008). More multidimensional examinations of immigrant foodways and health have taken place in the UK (Greenhalgh et al. 1998; Chowdhury et al. 2000). In Norway, there have also been some efforts towards broader conceptions of immigrant dietary habits and practices (Fagerli et al. 2005). And more recent publications by Bernadette Kumar, current director of NAKMI, make clear that identity, religion, culture, relative accessibility of foods as well as personal taste preferences all contribute to deciding what people eat (Helsedirektorat 2011; Kumar & Viken 2010). The purpose of this important widening of the gaze has nevertheless been instrumental. It has sought to aid healthcare practitioners' and authorities' understanding, initiatives and interventions aimed at immigrant groups through enhancing the 'cultural competence' and knowledge among relevant health service personnel (ibid.). With regard to nutritional information, the aim has been to make it more legible to immigrant groups themselves through delivery via a variety of channels (not simply top-down written, translated information) (ibid.).

Food and wellbeing: perceptions and practices beyond the biomedical frame

Elsewhere, anthropologists and sociologists have shown that understandings of food as either 'heating' or 'cooling' can determine food choices in relation to health in Iranian, South Asian and Chinese communities in the UK (Bradby 1997; Harbottle 2004; Homans 1983; Wheeler & Tan 1983). This dichotomy is part of a broader classificatory system in ancient Greek and Islamic medicine that identified the world and its contents as being composed of variable combinations of four substances (blood, yellow bile, black bile, phlegm) associated with

particular qualities (respectively, hot/wet, hot/dry, cool/dry, cool/wet) (Anderson 1984). Parallel humoral systems exist, though differing in detail, as part of traditional healing systems elsewhere, such as in Traditional Chinese Medicine and Ayurveda (Unschuld 1985; Wujastyk 2003). It has been noted that over time, in lay perception, wet/dry qualities have tended to become collapsed into the hot/cool ones such that this latter dyad persists in everyday knowledge (and sometimes practice) after other aspects have been forgotten (Anderson 1984). This is born out by findings from several enquiries into immigrant foodways (Bradby 1997; Harbottle 2004; Homans 1983; Wheeler & Tan 1983). Moreover, as will be seen in Chapters 4 and 6, several of my Nepalis respondents also applied this binary to certain situations, for example when having a cold or during pregnancy. And it was my intention from the outset to explore the dietary habits and practices of my Nepali respondents in their own terms, and thus not be limited by a biomedical frame.

Yet these aforementioned studies also show how people combine biomedical with ostensibly incompatible dietary belief systems from, for instance, Traditional Chinese Medicine (Jing 2000; Wheeler & Tan 1983) or Ayurveda (Bradby 1997; Homans 1983), in the process creating novel ways in which to express personal agency in food matters. My focus on the maternity-related eating habits of Nepali women develops this analysis further, and sheds light very clearly on this phenomenon. The foodways of people in diaspora are neither entirely or definitively ‘traditional’ nor ‘modern’, nor of coherently different medical systems. They could instead be said to constitute a ‘bricolage’ (Lévi-Strauss 1972): people improvising in a structured way, using their personal knowledge and experience of the health-related paradigms they have encountered or have particular access to (biomedicine as well as an Ayurvedic, humoral-based model of health and illness in the case of my Nepali respondents) to actively inform and construct their responses. How, in the context of dominant biomedical nutritional discourses surrounding pregnancy in Norway, the Nepalis I encountered created such alternative foodways and maternal wellbeing is the substance of Chapter 6. Following a close examination of the forms and flows of dietary information available to pregnant and postnatal women in Norway (Chapter 5), it explores the kinds of adaptations made by Nepali women and their families when living in a country very different from Nepal.

Ante- and postnatal foodways: looking beyond biomedicine and its individualistic preoccupations

Making maternity-related foodways a specific topic is interesting for a variety of reasons. Pregnancy obviously poses certain health challenges to a woman. And as with more general health-related matters, the possibility for moving between various medical paradigms (including biomedicine) to negotiate these exists. Thus ante- and postnatal dietary habits and practices

offer particular scope for examining the aforementioned issues of biomedicalisation and alternative responses to that. Yet at the same time, the mother-to-be is also ‘growing’ a new person. In relation to the unborn child, its body and identity may be considered to be in primary, active formation (Busby 2000). A biomedical nutritional discourse privileges physical formation over social and cultural aspects (Chen 2009; Harbottle 2004), but the influence of social relations – family, society and the state – is also highly relevant. These ‘bodies’ all pay increased attention to, and potentially seek to influence (through advice and/or information), what the pregnant woman eats. As already mentioned, Norwegian state-endorsed dietary guidance and other prominent sources of advice for pregnant and breastfeeding women, for example, are firmly rooted within a biomedical model of nutrition.

As already suggested, another major concern of this study is the emphasis on self-regulation, personal responsibility and the individual (Coveney 2006; Foucault 1991a, 1991b), discernible in contemporary nutrition discourse, not least in eating habits present in Norwegian society (Middelthun 2009) and especially within maternal health-related resources (Helsedirektorat 2009; Helsenorge 2014b; Matportalen 2015a, 2016b). This is potentially at odds with a sense of collective responsibility for pregnant women’s health identified in South Asian groups in India (Donner 2008b) as well as in the UK (Homans 1983). As will be shown (and critically analysed) in Chapter 5, Norwegian public health guidance presents a biomedically-appropriate, Norwegian-style eating pattern as normative. However, the antenatal and more particularly postnatal practices of the Nepalis in Norway I encountered, as Chapter 6 relates, challenge the individualistic and narrow interpretations of maternal diet and care officially promoted in their host country.

Foodways and health: the limitations of state claims to authority

Regardless of the medical tradition(s) they are exposed to, the agency of any given individual in deciding what to eat needs to be acknowledged, as does the recognition that food choice is a product of social relations (Murcott 1995). Keane (1997), for example, has demonstrated how, among white and Afro-Caribbean men and women living in southeast London, ‘healthy eating’ advice they received was interpreted in varying ways. Information from health professionals was considered important for specific situations, such as advice on feeding children, during pregnancy and when raising young children (ibid: 180 – 6). Yet in other situations “embodied knowledge” and that gained from personal experience were often asserted as more authentic bases from which to make judgements about food and their own health (ibid: 187). Furthermore, discussing the subject among informal networks meant that guidance or advice (be it from a health professional, advertising, magazine or some other source) was often compared and

contrasted with other information, potentially undergoing reformulation and adaptation in the process (ibid: 188 – 89).

Accordingly, this dissertation also examines the influence of informal networks (most commonly friends and family) on the foodways of the Nepalis I met, especially with regard to pregnancy and the postnatal period. Other anthropologists working on similar topics have already noted the place of family and friends in providing dietary advice and acting as sources of authority (Bradby 1997; Donner 2008b). Moreover, we can see how the effects of these informal networks can derail assumptions present in many scientific enquiries into eating habits (as well as ‘top down’ health promotion strategies) that food choices are made and food information either ‘accepted’ or ‘rejected’ on an individualistic basis (Murcott 1995; Keane 1997). This exploration of my Nepali respondents’ engagement or otherwise with dietary practices promulgated by Norwegian health authorities and related sources – the degree to which they were conformed with or actively resisted – therefore foregrounds the conditional nature of biomedicine in spite of its hegemonic status in Norway. It also enables me to offer some initial observations on these Nepalis’ relationships, as subjects and immigrants, to the Norwegian state and the dominant cultural practices it promotes.

My focus on sources and claims to authority also makes plain the importance of a fieldwork-based approach for elaborating on the contexts and contingencies that inform people’s food choices in relation to health (as well as more generally). More philosophical, spiritual or religious aspects of food choice and wellbeing are not within the scope of this work. That said, deciding what one eats in relation to health can also be seen as part of the idea of food as ‘good’ or ‘bad’ to eat, which encodes a moral imperative in our relationship to it (Coveney 2006; Middelthon 2009), a concept that is touched on in Chapter 5.

Disaggregating the category of ‘South Asian’

An additional theme that this thesis critically examines is the category ‘South Asian’ and its current, widespread use within public health research and policies in Norway (but also worldwide). To date public health researchers and research in Norway have tended to look at the dominant South Asian immigrant groups, notably Pakistanis and Sri Lankans. This is for good reasons: they are by far the most numerous, in 2016 approximately 43,000 Pakistanis and 17,000 Sri Lankans were resident in Norway (SSB 2016a). Moreover, for ease of discussion and generalisability of results, these two groups are frequently collapsed together with any other constituent members (as in public health and biomedical research from other countries) into the category of ‘South Asian’. Yet aside from diversity in culinary practices, variations in socio-economic, caste and class status also exist within and between the different immigrant groups –

present in their homelands but also often traveling with them into diaspora (Ballard 1997; Ray 2004). In Norway this plays out most notably when the Nepali population, coming almost entirely from an urban, educated middle-class background, are compared with the Pakistani group, whose origins were generally more rural and less educated. Thus by focusing only on Nepalis in Norway this dissertation builds on the very limited existing research (Malla 2005) to introduce some necessary specificity and nuance into analyses of South Asian diaspora foodways in Norway.

Methodology

A variety of approaches were required to investigate the question of how Nepalis in Norway (and especially those who were pregnant or had recently given birth) choose to eat, the ways in which they balanced potentially competing ideas of what constitutes an acceptable diet. My research methods combined people-centered and text- and internet-based resources. For the people-centered part, my aim was to attend to cognitive and behavioural aspects of life (Hahn & Inhorn 2009), watching and learning about behaviour through participant observation, and then trying to understand people's ideas through more direct and detailed enquiries, usually via interviews.

The most significant aspect of fieldwork therefore involved close contact with – getting to know and learning from – Nepalis living in Norway's capital city, Oslo, as well as some resident in the nearby university town of Ås (approximately 40 kilometres south of Oslo). The majority of my research thus focused on this geographic area in and around the Norwegian capital. During fieldwork I spoke with people in a variety of situations: single students, young married couples, families with children and a few older Nepalis who had been in Norway for ten years or more. In total, I met and talked with over forty Nepalis, and formally interviewed twenty-two (twelve women and ten men).

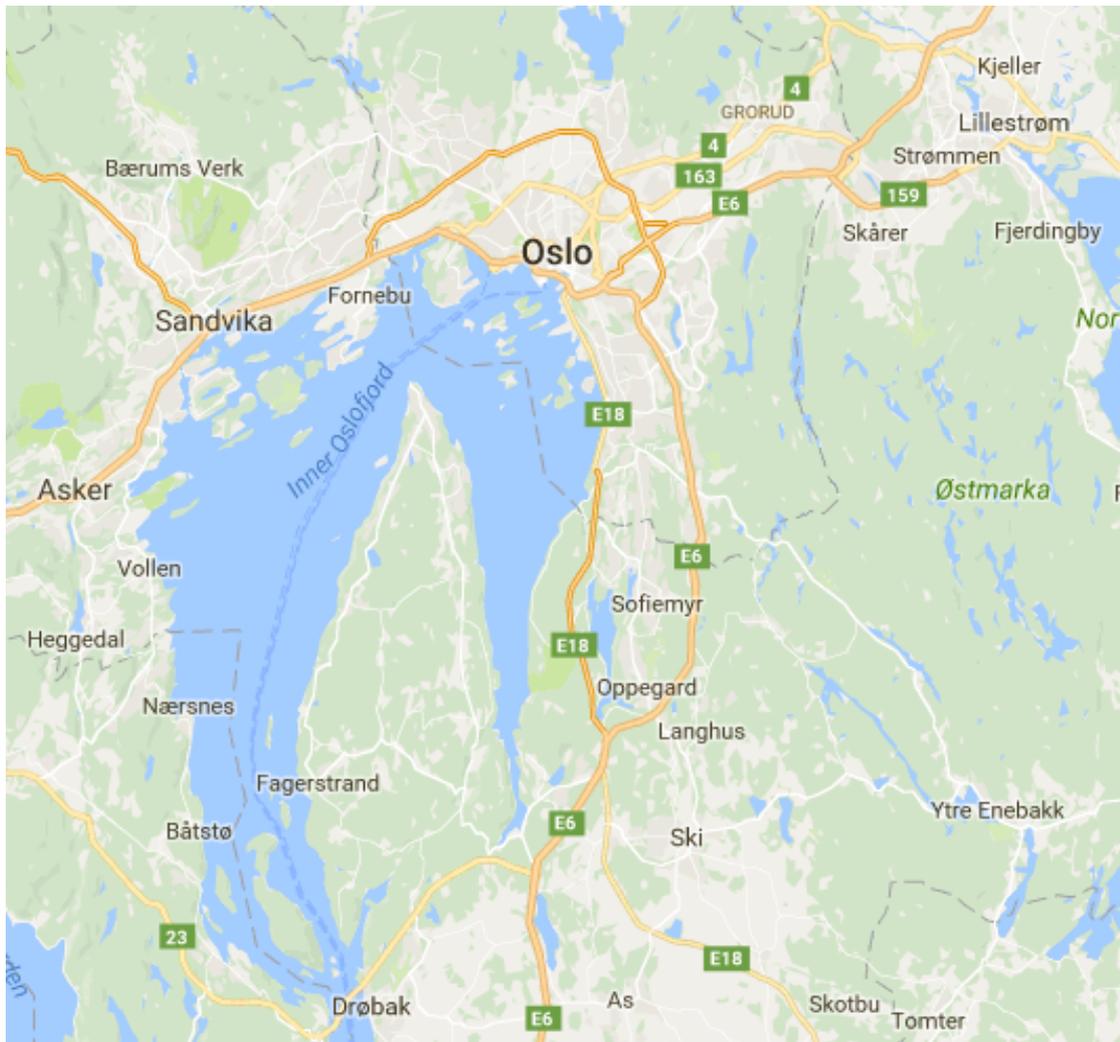


Fig. 2 Map showing Oslo and Ås (Ås is marked as 'As' on the map) (Google maps 2016b)

One thing common to nearly all my research participants was that they were currently studying or had done so when originally coming to Norway. As detailed in Chapter 2, this was often as part of a scholarship scheme that runs between Norway and certain lower-income nations, the so-called 'Quota' scheme (SIU 2005). In addition, higher education fees in Norway are very low compared to other European countries or the US (SIU 2007), enabling some of those I met to have continued with additional courses once they finished the initial course or for their spouses to begin studying instead. Thus the Nepalis I encountered often had a university-level education from Nepal and had or were attending postgraduate courses in Norway. They appeared to come from quite wealthy households (wealthy enough to have afforded a university education back in Nepal), socio-economically what might be described as 'middle class', a term that I will explore in much more detail, not least following Liechty's (2003) seminal work, in the coming chapter. As already mentioned, this is in contrast to other, more established, immigrant groups in Norway such as the Pakistanis, who, from less wealthy or educated

backgrounds, were initially invited to fill labour shortages, or Sri Lankans and Vietnamese who came by-and-large as refugees. This is a topic I will touch on again in Chapters 2 and 3 as it is important when interpreting my findings as well as discussing current public health perceptions of South Asians and their foodways.

I had intended the data gathering to be very general to begin with, thinking that information relating to my research questions might arise on an *ad hoc* basis during informal conversations and from the kind of communication that accompanies ‘hanging out’ together. More specific details I then planned to gather through semi-structured interviews once participants and I were more familiar with each other. This strategy for a more organic, initially less-directed form of data gathering proved, however, to be a naïve assumption on my part, not suitable to the busy lives of those I was seeking to work with. Juggling the usual requirements of family, work and/or study and any other commitments, it soon became apparent that those I met with had understandably limited time to speak with me. When we did come together their expectation, moreover, was that I would ask specific questions; furthermore, I quickly gained the sense that in quite a few instances my contact with them would most likely be limited to just one meeting. Initial encounters were, therefore, usually scheduled and structured. Given the topic of my study, several participants made generous invitations to eat with them. These were excellent opportunities for participant observation, of course, but as I was expected to carry out interviews within this time there was often a palpable ‘gear change’ between the two processes that felt rather unnatural.

So while a more free-flowing, gradual form of data collection would be appropriate in a more immersive setting, in common with urban anthropology and the anthropology of dispersed groups (Harbottle 2004; Ray 2004) the context in which my research took place did not allow for this. However, the Nepali School, a weekly language and culture club for Nepali children (discussed in Chapter 2) offered the best means for more unstructured engagement. And it was during these weekly gatherings that I felt rapport developed most fully and at the same time that I really learned a lot. Similarly, the ‘emergency *ghee*’ conversation that begins this work arose during a get-together of Nepali woman friends that one of the teachers at the Nepali School invited me to. It was there, over a lot of delicious food and amidst much laughter, questions and ‘hanging out’ combined that I was allowed a really enjoyable experience as well as the chance to gain valuable information in an ‘offguard’ manner (see Chapters 4 and 6). I also joined a Nepali New Year celebration, attending a gathering of twenty or more Nepali families as well as single students and friends, eating and drinking the special foods of the occasion together. Hence I was able to record and take note of the occasion and conversations around that time as well.

The relatively heavy reliance on interviews (see Appendix C) was not all disadvantageous, however. Aware of the limited time available, I found most respondents were very focused on providing as full as possible answers to my questions, as well generous with and keen to offer examples of the Nepali food they now ate in Norway. This experience of the concentrated and reflective nature of my interviewees and the detailed information they gave is echoed amply in recent work reflecting on anthropological methods, such as the edited volumes by Skinner (2012) and by Smith, Staples and Rapport (2015). These describe and discuss the relative roles and potential virtues of interviewing within anthropological research. Interviews can be considered “a special, productive site of ethnographic encounter”, the relational nature of the encounter generative of “a very particular way of knowing”, whereby the interviewee is enabled by the very nature of this methodology “to reflect, comment upon and interpret their own actions and the world around them in their own terms” (Smith & Staples 2015: 4); a space is opened up “for re-imaginings and re-articulations of personal and social practice” (ibid: 10). Skinner recommends that the interview be regarded “as *a part* of participant observation and not *apart from* participant observation” (2012: 35 – author’s emphases retained). Through chapters encompassing varied fieldwork, styles and settings, the contributing authors discuss how the interview is not only strongly embedded within anthropological practice but also the epistemic value of it within the subject as a whole.

This is significant because until relatively recently participant observation has been regarded as the methodological cornerstone of anthropological research (Holy & Stuchlik 1983), and although the primacy and nature of participant observation has been interrogated in the intervening years (see, for example, Faubion & Marcus 2009), other forms of data collection, such as the interview, are still often perceived as inherently subordinate to participant observations’ apparently discipline-defining activity. This notion is forcefully challenged by Hockey and Forsey (2012), however, who argue that the unequal status of research methods has been allowed to develop and solidify through an unhelpful, now inaccurate conflation of ethnography and participant observation. Instead they assert that in more Western-style settings (my example of a diaspora group within an urban European setting, a plausible example of this), research interviews readily reflect social interaction there, in being time-bounded, spatially dislocated and characterised by intimacy at a distance; hence they are a highly appropriate way of participating in peoples’ lives within these settings, and so ethnographic in their own right. They also posit the centrality of participant listening to the anthropological project: “many of the idealized attributes of participant observation” are achieved through the attentive, engaged listening to the interviewee that constitutes the ethnographic interview (ibid: 83). Using examples from their own research, Hockey and Forsey demonstrate that interviewees are not only “very capable of ‘showing’ us at least some of their lives through what they tell us”, but

also (and aided by judicious selection and timing of questions on the part of the researcher) entirely able to reflect on any gaps between what they say they say and what they might actually do. In doing so they rightly expose a certain arrogance in perceptions that only researchers can discern such disjunctions or contradictions, or in claims to the depth of insight that participant observation allows (ibid: 83 – 84).

On several occasions those I was interviewing would openly comment that prior to talking about them with me, they had not really thought about how their foodways differed from when they were in Nepal, or from what was done in Norway. Jyoti, for example, told me that not only did my questions “make us [she and her husband, Anil] more conscious about our food habits” but also aware, in the recounting of them, how much they had changed over the years without them really noticing “because it happened slowly”. “We don’t feel we change our habit”, Anil had then added, “but in fact it is slowly changing, every day”. This had then prompted him to recall how during his last trip to Nepal his mother had made him a rice meal in the morning (usual in Nepal) and he had had to tell her that he did not want it. Instead, he preferred and actually sought out bread, having got used to a more Norwegian-style breakfast yet still enjoying – and usually having – a rice-based meal in the evenings.

I intentionally did not conduct research in clinical or institutional settings because I wanted my focus to remain on lay perspectives, that is, on non-institutionalised medical or scientific ideas. The main reason was to minimise the possibility of being associated – by any of the participants – with biomedical or state authority or interests. This point was important: as an outsider and foreigner, especially one with a medical training (something I was open about), those I encountered could have connected me with state/biomedical targeting or surveillance of them. Secondly, it made the securing of research permissions much more straightforward – in Norway, as in the UK, any research associated with clinical settings is subject to substantially more complex and exacting reviews and requirements.

In addition to these people-centred interactions, I gathered and analysed nutritional guidance and information from government archives and websites, publications from Norwegian non-governmental organisations, the media, as well as websites from state-run *helsestasjoner* (Nor: public health centres) and other health/nutrition information readily accessible in the public domain. The principal source of state-produced information I used was that of the Department of Health (in Norwegian, the Helsedirektorat), which has an extensive electronic database of publications as well as archives stored at the department’s onsite library, the *Helsebiblioteket* (Nor: Health library). Websites included *babyverden.no* (Nor: the baby world), a resource directed specifically at pregnant women and new mothers, which is endorsed by the

Helsedirektorat, and Matportalen.no, a partnership between the Food Safety Authority (Mattilsynet), the Department of Health and the Norwegian Institute of Public Health (Folkehelseintituttet, FHI) among other national agencies.⁶ It provides information about food, health and physical activity, offering a putatively internally consistent (regularly updated) national resource, intended to enable Norwegian citizens' to make informed decisions according to their website: "[T]he objective of matportalen.no is to help the consumers make enlightened choices" (Matportalen 2013a). In addition to these, texts written specifically on the subject of immigrant health (Kumar 2011; Kumar & Viken 2010), as well as publications consciously aimed at South Asians in Norway were also reviewed. Together with the Norwegian public health research already mentioned earlier on, these are discussed in detail in Chapter 3.

As in many other countries, Norway has a plethora of food- and diet-related websites and blogs, such as *Matprat* (Nor: Food chat) (2016), which is tied to commercial interests (the Egg and Meat Information Office, in Norwegian the OEK, [*Opplysningskontoret for egg og kjøtt*]), as well as others seemingly more independent, for example *Sunt og godt* [Nor: Healthy and good] (2016). I did not come across any such websites or blogs in Norway that appeared to be geared specifically towards immigrants. That said, I accept that my language limitations prevented me from accessing such forums in Nepali, or strands of conversation within Norwegian-based Nepali 'chat' rooms on Facebook (or similar internet platforms) on the subject. However none of my informants spoke of using particular Nepali websites for information regarding food, health or diet. The only one, mentioned by one of my informants, was *babyverden.no*, which she checked at times during her pregnancy. Given that my research looked predominantly at Nepalis immigrants' response to more official health information in Norway, I decided not to include these less formal sources in my research, nonetheless remaining aware of their existence and potential for influencing decision-making.

Participant observation and semi-structured interviews with men and women identifying as Nepali but residing now in Norway were the paramount means of data collection. I recorded

⁶ The following governmental organisations are responsible for the content on Matportalen.no: The Norwegian Food Safety Authority (NFSA); The Norwegian Directorate of Health; The Norwegian Institute of Public Health; The National Veterinary Institute; National Institute of Nutrition and Seafood Research (NIFES); Norwegian Institute for Agricultural and Environmental Research; Norwegian Scientific Committee for Food Safety; Norwegian Radiation Protection Authority; Food and health authorities in other countries. Matportalen.no was launched by the Minister of Food and Agriculture, Lars Sponheim, in May 2003. The website was one of the initiatives in "*Handlingsplan for forbrukerretting av matpolitikken 2004-2005* [Nor: Action plan for consumer-oriented food policy 2004 -2005]" (Matportalen 2013a).

notes on the former, and, where at all possible, made audio recordings of the latter, transcribing these afterwards. From the outset, I had decided to work in a combination of English (my native language) and Norwegian, having acquired moderate competency in Norwegian language, which improved during the fieldwork period and was adequate in the majority of interviews. A significant proportion of my respondents spoke English at least moderately fluently, and as will be seen in Chapter 2, those studying in Norway did so, for the most part, via English medium. I also have some knowledge of Nepali, which though inadequate for interviewing purposes was useful in understanding certain foodways-related terms and their wider semantic network. Not having worked in the native language of my participants is, I recognise, a limitation of this study. Some of my respondents actually indicated (and I myself observed) that not working in Nepali would actively prevent me from communicating with a considerable number of Nepali women living in Norway – the more major intended subjects of this study – as they tended to be less fluent than their male counterparts in either English or Norwegian. That said, the extra time it therefore took to engage with people (to make sense of what they told me), the keenness with which all parties sought to clarify any Nepali terms used, as well as the nature of longer term fieldwork in enabling my relations with some Nepalis to develop, may have had some advantages: both me and many of my respondents really strove to make sure meanings and explanations were clear. Thus I managed to have what I consider were informative and wide-ranging discussions with most of the Nepalis I encountered.

Limited financial resources also prevented me from employing a Nepali research assistant who could have helped with collecting data in Nepali. Costs of living in Norway are very high and wages commensurate with this, so while hiring research assistants is common and affordable in a number of research settings (especially in lower-income countries), in Norway this is not the case. A slight but possible side-effect of this was that any loss or slippage of meaning occurred only between my interlocutor and me; the absence of a translator meant there was no additional ‘filter’ through which any information had to pass before reaching me. During my Master’s fieldwork in Nepal (Vidnes 2011), where I had used a local research assistant as translator, this problem had occurred, adding a layer of uncertainty to the interpretation of my findings then. This time I avoided that issue but must acknowledge the lack of accuracy that not working in the participants’ native language has in certain instances brought. That said, almost all the Nepalis I encountered during fieldwork spoke either Norwegian and/or English to a very high standard and I was able to gain a significant amount of useful information this way and that I understood clearly. Furthermore, given that quite a substantial element of my enquiry considered how Nepalis in Norway engaged with dietary information available there, almost all of which they encountered either in Norwegian or English, it seemed reasonable and in some ways appropriate to work in these two languages.

Aside from the matter of the languages used in this study, there was one other notable limitation to this research: during the time designated for fieldwork I had to undergo medical treatment. The nature of this meant that I was at times limited in what I could eat when invited to by my Nepali respondents, and it was also unforeseeable how much rest and movement was best for me, making it difficult in some instances to engage with them. Overall, two long periods of abeyance were necessary, the second essentially ending the fieldwork after only eight months. While disappointing and inevitably affecting the quantity of findings, these interruptions and the longer time in total taken to carry out the research did give me opportunities to reflect on information I had already gathered and identify gaps in my data each time I returned to the field. Therefore, using what there is, I believe it is still possible to present some very important observations, which through discussion and analysis in relation to my research questions, enable me to make the four key arguments outlined at the beginning of this thesis, as well as relate my findings to wider discourses in anthropology and public health.

More generally, the study of food habits, particularly, consumption, are known to be fraught with difficulties, and potential inaccuracies (Nestle 2007; Pollan 2008). A major problem is to try and establish accurate records of how people actually prepare food and eat it as opposed to what they say they do. Short of being present with people whenever they make and/or consume food – practically impossible in an urban, European context with busy people, as well as disturbing to pre-existing dynamics and behaviours – researchers usually have to rely to varying degrees on what their respondents recount. This has been shown to differ from practice (Basiotis et al. 1987; Nestle 2007). And in relation to health, it is common for “people to underreport the intake of foods considered undesirable and to overestimate consumption of “healthy” foods” (Nestle 2007: location 453). Furthermore, while what is eaten is subject to patchy recall, so are the origins of dietary information. Multiple sources of information about food appear (from advertising, television and radio programmes, printed media, friends and relatives), and the way they intersect and combine can make it hard for someone to pinpoint exactly which bits of information come from where. It can also make it difficult to distinguish between official state information and others. Both these issues have been noted in previous ethnographic work (Keane 1997: 180), and persist as methodological challenges. I have no doubt that my research findings were affected by these phenomena as well. Nevertheless, in taking seriously the ways that my Nepali respondents’ interrelated foodways and perceptions of wellbeing while living in Norway – as they communicated them to me (and, where possible, supplemented by my own observations) – my research offers important and valid insights into their experiences. As a relatively small population relative to other immigrants to Norway, about which little is currently known, this work provides significant new information about Nepalis living in Norway. More broadly, the research presented here engages with, and critiques and complicates existing

public health discourse surrounding the dietary habits and practices of South Asian peoples living in diaspora.

Ethical considerations

Gaining consent from those I engaged directly with during the research was, obviously, extremely important. Yet, 'informed consent' within qualitative research is a complex issue (ASA 2011; Ellen 1984; Glesne 2006). During the course of participant observation, it is known that written consent can hinder more unobtrusive elements such as informal interactions and observations (Glesne 2006). Furthermore, over time and as I experienced, relationships between me and those I regularly worked with developed, and new and unforeseen situations arose. Consent, therefore, became a process, one that required renegotiation during the course of the study (as, indeed, is noted in the ASA Ethical Guidelines 2011). In these cases I therefore worked on a case-by-case basis. Written consent was sought where possible and most appropriate, for example prior to scheduled interviews, where I first gave the interviewee a written 'Information sheet', available in either Norwegian or English (see Appendix A).

At the outset of any interview-type encounter, whether formally arranged or informal, I endeavoured to communicate the following key points to all those I worked with:

- My name, that I was a student at Brunel University, and that I was studying for a PhD in anthropology.
- A very brief description of my research topic: namely, that I was interested to learn from Nepali people living in Norway about the foods they ate, their ideas about food in relation to health, and especially in relation to diet and pregnancy.
- That their participation was entirely voluntary.
- That they were free to stop at any time, and with no negative outcomes for them if they decided to do so.
- That any information they gave me would remain confidential because I anonymised my data.
- That the information gathered from the research would be used to write a PhD thesis.
- That my main funding for the research came through a university PhD scholarship.

In non-formal interview settings this was done entirely verbally, any consent gained also given verbally. During the scheduled interviews, having read the Information sheets, I used a second, 'Background data' sheet (see Appendix B) to check if the would-be interviewees had any questions and if they were happy that they understood the information and could confirm they were willing to continue taking part in the study. Their answers were recorded, written either by them or me (if they had responded verbally) on the sheet.

In practice, many of the Nepalis I worked with had, as school or university students or in their current studies, personal experience of carrying out their own research. Consequently, the majority openly expressed familiarity with notions of consent, written or otherwise. Several times I was asked “what is your methodology?” my reply met often with “ah, qualitative research”; and by a few Nepalis studying in Norway there were enquiries about my “research clearance”, some subsequently sharing with me their experience of what they found (compared with Nepal) to be “strict” system operating in Norway. Most considered this to be a good thing, authorities in Nepal often regarded, at least by those I spoke with, as prone to corruption (see Chapters 4 and 6).

Regarding research permissions and affiliations, if based at a Norwegian higher education establishment formal academic research in Norway requires that there is a Norwegian academic involved, in the case of PhD research acting as a co-supervisor. Application to the relevant Research Ethics Committees is then done through this co-supervisor. I had sought and gained a Norwegian co-supervisor, Dr Benedikte Lindskog, an anthropologist based at the University of Oslo’s *Instituttet Helse og Samfunn* (Nor: Institute of Health and Society), within the Section for Medical Anthropology and Medical History. She and I then spoke with officials at the Norwegian Regional Committee for Medical and Health-related Research Ethics (*Regionale komiteer for medisinsk og helsefaglig forskningsetikk*, or REK), and learned that there was no need for me either to receive a clearance from them nor, in fact, to send in an application.⁷

Prior to commencing fieldwork, I had already gained full ethical clearance from the ethics committee of Brunel University so this was therefore sufficient for my research to go ahead in Norway. To add to my legitimacy both within Norway as well as to engage with scholars in the field, I gained affiliation with the aforementioned Section for Medical Anthropology Medical History. This and conversations with Dr Lindskog as a local co-supervisor have been very useful for carrying out and completing this research project. Several of the Nepalis I worked with were past students of the university, some even having been based at the same Institute. Such familiarity with my place of affiliation further added to my credibility as researcher.

⁷ This was on the basis of two reasons. Firstly, Non-Norwegian projects (funded and based abroad) do not have to register unless they are directly related/coordinated to a project funded and carried out in Norway, which means that ethical clearance from the country to which the project 'belongs' is enough. Secondly, ethical clearance from REK (or a confirmation that the project is outside their jurisdiction) is only relevant for projects that deal with sensitive data or genetic/biological data; my project, the nature of the data collection, as well as the topic of my research project all fell outside REK's remit.

Chapter Outline

Following on from this introduction, Chapter 2 discusses how Nepalis come to be present in Norway, as well as the particular segment of contemporary Nepali society that they seem to represent. After presenting some basic population statistics, focus turns to the specific Nepalis I worked with in and around Oslo. While many came to Norway initially as temporary educational immigrants, increasing numbers now hope to remain there (at least for some time), although several also expressed the hope of returning to their homeland in later life. My Nepali respondents were middle class, both in Nepal and now in Norway. Extant anthropological studies on the emergence of a middle class and ‘middleclassness’ (Donner & De Neve 2011) in South Asian contexts, including in Nepal (Liechty 2003), have shown how the class distinction is created and maintained, in part, through foodways and the role of women (Caplan 2002, 2008; Donner 2008a, 2011; Ray 2004). Through my findings, I thus identify how Nepalis’ middleclassness in Norway can be discerned, including relevant markers of Norwegian middleclassness to give appropriate contextualisation. At the time of my research the Nepalis I met presented themselves, at least in conversation and at festivals and meetings, in relatively homogenous terms – caste and ethnic group differences subsumed to a generalised ‘Nepali’ identity. The chapter concludes, however, with a consideration, voiced by a few of the Nepalis I worked with, that the situation was set to change: the growing Nepali population in Norway likely to result in fragmentation of a coherent sense of ‘the whole’ in favour of an increased distinction between separate groups, along ethnic but also political and possibly other lines.

Before the foodways of the Nepalis I encountered can be effectively explored in relation to their perceptions of health and wellbeing (maternal or otherwise), it is necessary to contextualise the public health climate in which they lived. Chapter 3 therefore concentrates on how Norwegian public health writers and institutions use the biomedical paradigm (dominant within Norway’s health care system) to relate health and diet among the nation’s South Asian immigrant population. A common theme within that public health discourse is then delineated: that South Asians have a particular tendency to certain chronic diseases (diabetes, cardiovascular disease), for which their foodways in diaspora are partly to blame. Working from the assumption that cultural practices inform eating habits, several of the Norwegian researchers are shown to present the cultural practices of these groups as possible instruments to facilitate ‘healthier’ foodways among the South Asian population along (the biomedical) lines recommended by public health practitioners in Norway.

When read in conjunction with the chapter that follows it, also made clear is the need for greater discrimination within public health research than the term ‘South Asian’ permits. Discussion of research among the (much more populous) Pakistani groups living in Norway, shows how their

foodways (as well as other factors, including education level), while similar in some ways also varied significantly from my Nepali respondents. Accordingly an attitude within Norwegian public health research is identified, one that through a biomedical frame ‘lumps together’ potentially very different South Asian groups, often ascribing ‘unhealthy’ practices within each to ‘culture’.

Having located my respondents both geographically and socially, as well as made clear the public health discourse regarding South Asian immigrants’ foodways that surrounds them in Norway, Chapter 4 then examines the dietary habits and practices of the Nepalis I worked with. In particular it examines how they related what they ate to feelings of health and wellbeing. Through an analysis of their post-immigration dietary habits and practices, the view emerges of a group comfortable with the application of biomedical nutrition-based ideas, yet also ready to draw on alternative evaluations of wellbeing that included considerations of the heating/cooling qualities, digestibility and taste of foodstuffs, as well as feelings of satisfaction and, for some, the importance of commensality. Discussion of other relevant ethnographic works feature where relevant to help place my findings in a broader anthropological context.

Chapter 5 then offers further background context, in this case focusing on attitudes to maternity-related eating habits and practices in Norway, as presented through official state guidance as well as some recent public health research. Alongside a Norwegian state and public health research approach predicated on a biomedical account of food, as previously discussed in Chapter 3, there is a heavy emphasis on the antenatal period. There, moreover, as well as in the (considerably less detailed) postnatal dietary advice, attention is directed much more towards the health of the child than the mother. Therein, a biomedically-appropriate diet that follows a more-or-less Norwegian pattern is shown to be promulgated, presented as normative. Overall, regarding the mother and mother-to-be a highly individualised concept of responsibility for health, one that also encodes notions of self-regulation and a degree of morality, becomes discernible.

Again with the relevant public health context now laid out, in Chapter 6 we return to the Nepalis I encountered, learning of their foodways in Norway during pregnancy and in the initial months following childbirth. My findings and analyses once more show a Nepali approach to ante- and postnatal foodways where (as with health more generally) biomedical theories co-existed with assessment of foods’ potential harms or benefits that appealed to other healing logics, in this case often the Ayurvedic categories of ‘hot’ and ‘cold’. Moreover, the period following birth appeared to be of special significance to the Nepali women I met, especially in relation to maternal foodways. There, the new mother’s wellbeing and bodily recovery were emphasised,

Nepali female friends and also any relatives also living in Norway making special efforts to provide specific foods and support to the new mother during the months after the birth. The impression thus gained was that the health of the mother as well as the child (who clearly benefitted too, albeit indirectly) was regarded as a collective responsibility, shared by family and friends rather than the sole preserve of the individual mother herself. These conclusions form two of the three main analytical points made in the chapter: firstly, the significance of social relations both in pregnancy and postnatally for my Nepali respondents; and secondly, their evident prizing of maternal wellbeing within this. The third point concerns the relevance of my respondents' specific class- and experience-based background when examining their interactions with Norwegian state-endorsed food-related health guidance and services. By considering the variable engagement with official ante- and postnatal dietary guidelines as well as related infrastructure some preliminary indications as to their perceptions of state authority more generally emerge. In relation to maternal health it is possible to see the Nepalis I worked with as agentive and judicious users of what the Norwegian state offered: mostly willing to take up and grateful for the high standard of biomedical services provided there, yet also confident enough in their own, other values and practices to sometimes pursue dietary measures well outside of any official Norwegian guidance.

When Chapters 5 and 6 are read together, the postnatal care of the mother and sense of group accountability that was so evident among the Nepalis I worked with stands out as significantly different from Norwegian expectations, at least as presented in maternal health research and official guidance. Taken together with the variable engagement Nepali women made with such information, these instances serve to exemplify the contingency of the Norwegian state-endorsed advice and norms described, highlighting how anthropological enquiries such as this one can help guard against apparently self-evident 'truths' of hegemonic systems such as biomedicine.

Finally, in Chapter 7, the various conclusions from the preceding chapters are brought together. Returning to the ethnographic vignette that opens this thesis, I show how particular elements within it relate to each of the key arguments made in this thesis. Each chapter is then briefly reviewed before the key arguments are reiterated in greater detail, drawing on the findings from the intervening chapters to consolidate and substantiate them. In addition, I explain how my findings speak to the theoretical frameworks guiding this study. I end by describing the contributions I think this thesis makes to anthropology in general as well as to critical medical anthropology in particular and, looking outwards, identify possible avenues for future research.

Key arguments

Overall, this thesis thus sheds light on the particular ways in which Nepalis, as distinct members of a South Asian diaspora population, engage with food, ideas about health and wellbeing, and the biomedical healthcare structures of the state in the context of ante- and postnatal foodways. On the surface then, in taking seriously the non-biomedical aspects of Nepalis' dietary habits and practices and lifestyles in Norway, the major contribution of my ethnography is to add a different voice to the debate there surrounding South Asian foodways in relation to health. Underlying this, however, I identify certain limitations and tendencies within the Norwegian state's public health approach and discourse, thus pointing to the need to look beyond their dominance. And so through the findings presented in the coming chapters four key arguments are advanced, which taken together offer a broader analysis of the situation than has hitherto been achieved.

Firstly, there is the overgeneralisation of 'South Asians' into a single category that results from their being combined together in public health and other official studies and policies in Norway and elsewhere. In response, I argue for the need to disaggregate this homogenising stance, drawing on my findings to show why this is necessary. A crucial factor in my analysis here is the 'middleclassnesses' (Donner & De Neve 2011) of the Nepalis I worked with, which is discussed in depth in Chapter 2 yet persists as an important interpretive undercurrent throughout the subsequent chapters.

A second key contention pertains to the hegemony of biomedical models and conceptions of nutrition in relation to health as well as ante- and postnatal wellbeing in Norway, which are detailed in Chapters 3 and 5, respectively. Based on my results, I argue for the necessity of recognising how Nepalis (as indeed most people in general) move between these and other, non-biomedical notions and practices of health and wellbeing. As the ethnographic findings and interpretations presented in Chapters 4 and 6 make plain, I am able to show how my Nepali respondents could (and did) balance their understandings of diet and foodways from more than one medical paradigm to personally satisfying effect.

Thirdly, as Chapter 5 illustrates particularly clearly, there is a strong propensity evident within Norwegian public health and state-endorsed ante- and postnatal dietary guidance to place overt emphasis on the individual mother's responsibility for her own health in order to benefit the coming or newly-born child. This emphasis appears to ignore the potential for alternative distributions of responsibility for, as well as focus on, both offspring *and* mother. Furthermore, a rhetoric of 'normalisation' is legible within the official Norwegian publications, which present appropriate foodways as those that conform both to biomedical definitions of 'health' yet also to

typically Norwegian patterns of eating. However, as Chapter 6 shows, there is a need to recognise that in contrast to the Norwegian emphases, the Nepalis I worked with focused on the mother's health in its own right as well, within this incorporating certain typically Nepali food related habits and practices. Furthermore, the care of both mother and child, pre- and especially post-partum, was a much more collective enterprise for them, relationally shaped, with Nepali friends and family offering practical assistance as a matter of course.

My final argument relates to the limitations of the Norwegian state's authority regarding advice on health and foodways more generally. Although, as will be seen (in Chapters 3 and 5), the state-endorsed guidance is often presented as somehow fundamentally or self-evidently true and therefore 'only reasonable' to follow, the Nepalis I encountered – a well-educated, well-informed group – I show to have engaged only selectively with it. Instead and as well they found other sources of authority and kinds of resources, several of them collective and drawn from networks of Nepali friends and relatives, most living in Norway but some also in Nepal.

Let us begin then by considering the Nepalis I worked with: how they came to be present in Norway, the tranche of contemporary Nepali society they appeared to represent, and how this impacts on their ways of being in this particular diaspora setting.

Chapter 2 – Nepalis in Norway: Origins and Middleclassness

There have been links between Nepal and Norway at least since the early 1950s. At that time, Norwegian protestant missionaries established a hospital, having gained the then King of Nepal's permission, on the condition that no efforts were made to convert the local population (HimalPartner 2016). Further Norwegian Christians, qualified in other disciplines such as engineering, then came. They founded a technical training institution, aimed at offering the Nepalis who attended education in specific technologies, notably hydropower (Westborg Steel, personal communication, 29.10.2013).⁸ This was already a field of expertise and an economic resource in Norway, and Nepal's similarly mountainous terrain could, in the Norwegians' estimation, provide Nepal with comparable benefits (ibid). Over the subsequent decades, specific partnerships around capacity building, especially in relation to hydropower and health (Normisjon 2016) were formed, as well as those intended to foster greater cultural development and knowledge about Nepal among interested Norwegians (NNF 2016). Thus began a strong educational link between Nepal and Norway, with Nepali students both attending Norwegian-funded institutions in Nepal as well as starting to come to universities in Norway as part of their training. The first to host visiting Nepali students was the engineering department of NTNU (*Norges teknisk-naturvitenskapelige universitet* [Nor: Norwegian University of Science and Technology]), located in the city of Trondheim. At the time of my research, Ravi, a leading figure in both the national and Oslo-based Nepali community,⁹ estimated that "over half" of the Nepalis present in Norway were still students, "here to study for Masters' degree and PhDs".¹⁰

The purpose of this chapter is to sketch out reasons for Nepalis' presence in Norway, as well as the particular tranche of contemporary Nepali society that they appear to represent. It is not intended to be a detailed demographic account. Apart from a few basic population statistics, the main focus will be on information related to the Nepalis I worked with living in and around Oslo. What will be shown is that while these Nepalis were initially temporary educational immigrants to Norway, the situation is now changing, with many at least hoping to stay on and work in Norway in the long term although they face certain obstacles. At the same time, several of those I encountered expressed circumspection on the topic, suggesting a potential return to

⁸ Heidi Westborg Steel is the current General Secretary of HimalPartner. She is also a granddaughter of one of the organisation's founders, David Westborg.

⁹ He was at the time president of the Non-Resident Nepali Association (NRNA) for Norway,

¹⁰ I have not been able to find any figures to back up this claim. That said, Ravi's position as a generally senior figure within the Nepali community in and around Oslo, who, at the time of fieldwork, was also high up in the leadership of the NRNA, would I argue have given him a reasonable overview of the situation and made his assessment – in the absence of more accurate data – relatively credible.

their homeland in later life. Those Nepalis coming to Norway are distinctively middle class and, I suggest, remain so in diaspora. This is a pattern that has been observed elsewhere. For example, Ballard's (1990) work with British Punjabis from two near but very different parts of the Punjab – one rural, relatively poor, less educated and lower class; the other more urban, prosperous, educated and middle class – shows how such class (and other) distinctions from the homeland effectively travelled with members of both groups into the diaspora.

For the Nepalis I encountered, to be middle class was not an etic ascription. The term was used (in English) more than once by some of my respondents, i.e. in an emic way, to define their self-perceived social position to me. In this chapter, I use my findings to delineate how Nepalis' middle-class status in Norway can be discerned. This is achieved by first discussing existing anthropological literature on 'middleclassness' (Donner & De Neve 2011) in South Asian contexts, including Nepal (Liechty 2003), which shows clear evidence of a rising middle class there; one where foodways, and the role of women, have an important role in creating and maintaining the middle-class distinction. Based on these, I draw out parallels between the South Asian context and that of the Nepalis I encountered in Norway. Moreover, through a consideration of some of the markers of Norwegian middle-class identity, I show that my respondents fitted in quite readily to the middle class of the host nation as well. In delineating how they adapted to their host nation, while at the same time maintained certain habits and practices typical of middle-class life in Nepal, I therefore identify ways in which these Nepalis effectively enacted their 'middleclassness' twice: in line with their perceptions of what their position should be in Norway, as well as through efforts to uphold the class status they had come from in Nepal. Finally, I consider the possibility that the growing numbers of Nepalis living in Norway at any one time may be leading to the loss of an overarching sense of Nepali identity among them, it being replaced instead by greater awareness of differences between particular groups, based on ethnicity, town or city of origin, political affiliations and even prior experience of having been an immigrant elsewhere. Establishing the middle-class status of the Nepalis I encountered is important because it will aid our understanding of their approach to foodways and childbearing, which are the subsequent focus of this thesis. Furthermore, it forms a major basis from which I will go on to make the first key argument of my research, namely the need to disaggregate the highly homogenising category of 'South Asian', currently in widespread use within public health discourse in Norway (as well as elsewhere).

Nepalis in and around Oslo

Compared with other South Asian groups present, the population of Nepalis in Norway is small, approximately 2000. According to the most recent figures published by the Norwegian Central Statistics Bureau (Statistisk sentralbyrå, SSB), the number of those identified as Nepali was

1,929: 1564 immigrants; 32 born in Norway to Norwegian-born parents; 125 Norwegian-born to immigrant parents; 15 foreign-born with one parent born in Norway; 114 persons born in Norway with one foreign-born parent; 79 foreign-born to Norwegian-born parents (SSB 2016a). While there are no exact figures for the number of Nepalis living in different parts of Norway, according to Ravi's estimates most live either in Oslo or the nearby university town of Ås, the rest settled in smaller but approximately equal numbers mainly in Norway's other major cities, Bergen, Trondheim, Stavanger and Tromsø (each of which has a university). Thus Nepalis living in Norway were concentrated in urban areas, usually in association with a higher education institution.

Focusing specifically on those Nepalis I encountered, twenty-five of the forty I worked more directly with, i.e. greater than half, had higher education qualifications (a bachelor's degree or equivalent, or higher-level degrees). Within this, the division between the genders was almost equal (thirteen men, twelve women), showing that Nepali women were often as educated as their menfolk (something also seen in Ray's (2004) research among middle-class Bengalis living in the US). All of the remainder had, to my knowledge, finished school. Of those Nepalis actively employed in Norway, eleven had professional jobs (doctors, nurse, academic, teacher, architect, engineer), the gender near-parity again evident (six men, five women). As alluded to in the introduction and will be seen also in Chapters 3 and 4, the profile of Nepali immigrants does differ from the other major South Asian populations in Norway, Pakistanis and Sri Lankans.¹¹ Both these latter two groups settled in greater numbers from the 1970s onwards, fulfilling mainly manual labour shortfalls in the burgeoning Norwegian economy in the case of Pakistanis (Maagerø & Simonsen 2008), the overwhelmingly Tamil population of Sri Lankan immigrants in contrast arriving as refugees from the civil war (Fuglerud 1999). Although education and socio-economic levels were more mixed among the Sri Lankans (ibid), the Pakistanis – most from rural areas of the Punjab – were in low-income occupations and had lower levels of education (Fagerli et al 2005; Lie 2004). The Nepalis I encountered, on the other hand, had, as already shown, received more education. Moreover, they were predominantly

¹¹ In 2016 there were 42,763 Pakistani immigrants living in Norway, 19,571 foreign-born Pakistanis and 16,455 Norwegian-born to Pakistani immigrant parents; in the same year, there were recorded 16,697 Sri Lankan immigrants living in Norway, 9,092 foreign-born Sri Lankans and 6,111 Norwegian-born to Sri Lankan immigrant parents (SSB 2016a). The total number of Indian immigrants to Norway has also risen considerably over the past twenty years (almost trebling, from 5,161 in 1995, to 14,087 in 2015) (SSB 2015: 16); in 2016 the figure stood at 19,411 (2016a). However, they are a relatively more recently arrived group than either the Pakistanis, Sri Lankans or Nepalis, albeit one evidently consolidating their presence swiftly as they are now more represented than the much more established Sri Lankan community and vastly outnumber the Nepalis living in Norway.

from urban settings – twenty-six of the thirty-four spoken with on the topic having been born and /or raised in large cities (Kathmandu, Pokhara, Patan, Biratnagar, Bhakatpur, Birgunj). Furthermore, of those born in more rural settings, several had spent some time prior to coming to Norway living in Nepal’s capital, Kathmandu, either for work or higher-level study.

As elsewhere in South Asia, Nepal has a caste system for its majority Hindu population, while at the same time recognising and according status to other resident ethnic groups. During conversations with my informants, when I asked about caste a usual response was that it was “not very important”, although one interviewee did admit that being from the same caste made it “a little bit easier to understand each other sometimes”. More generally, however, the message was that in Norway at least “we are all Nepalis”. That said, nearly all the Nepalis came from the higher caste groups – nine Baahuns, eight Chhetris and six higher caste Newars. Newars identify themselves as the indigenous inhabitants of the Kathmandu valley, who although regarded as a single ethnic group by other Nepalis, including in census statistics, in fact “possess an intricate caste structure of their own” (Whelpton 1997: 51). Yet while caste distinctions were once thought to eclipse a more general sense of being Newari, research has since shown an emergent sense of Newar identity among younger members of the group (Gellner 1986, 1997; Whelpton 1997). My other respondents were from the Gurung ethnic group with the exception of one, from the Limbu group. Over the past few decades caste has become more subordinate to class in determining social and economic distinction and advancement in Nepal (Liechty 2003) as well as in India (Donner 2011; Staples 2014). This will be considered in further depth in the ‘Middleclassness’ section below; however, at this stage it is important to note that the higher castes still dominate what are now considered the middle and upper classes in Nepal (Liechty 2003), and this is also reflected in the Nepali diaspora I worked with in Norway.

Education seemed to be the main reason that Nepalis had started to come to Norway. Aside from endeavours by the likes of HimalPartner, the Norwegian state also provided specific funding through ‘The Quota Scheme’, which offered over 1,100 scholarships annually – 800 for students from “developing countries”, 300 for those from “countries in Central and Eastern Europe and Central Asia” (SIU 2005: 2). Students usually had to come from a recognised partner institution in their homeland, funding – available for Bachelor’s Master’s and PhD programmes – most often covering one year of being based at a Norwegian higher-education establishment and a maximum of four years in total (ibid: 3 – 4). Students from Nepal, classified as a developing country, were eligible to apply and some of those I met had come to Norway in this capacity. The cost of following higher education courses in Norway is, however, generally very low; there are no tuition fees, even for foreign students, although a fee of 300-

600 Norwegian kroner is levied each semester (SIU 2007). Moreover, those foreign students fulfilling certain conditions, including being part of the Quota Scheme for example, were also eligible to apply for support from the *Lånekassen*, the Norwegian State Education Loan Fund (Lånekassen 2016). Thus many of the more recent student arrivals to Norway, such as one Nepali couple I met, Puja and Arjun, were self-funded, attracted by the prestige of a qualification from a ‘developed’ nation. Norway was not necessarily their first choice. The US, UK, Canada and Australia were mentioned as preferred options by several, but the number of postgraduate courses taught in English as well as existing contacts with Nepalis either with experience of and/or already in Norway meant that it was a relatively popular ‘second choice’ location.

Another attractive feature about Norway was the potential for “a high salary” if one were able to secure a job there. The motivation to come to Norway based on “salary” was something new according to Ashok and Ravi. Both men occupied just such a coveted position in fact. Now settled in or near to Oslo, each had raised their families there, having come as a postgraduate student over a decade (Ravi) or two (Ashok) earlier. That said, as senior figures in the local Nepali community, referred to by my other informants in highly respectful tones, they offered a useful and I think credible overview of the changing nature of Nepali immigrants to Norway. Ashok was quite vocal on the subject:

“Initially, Nepal immigrants were all hard-working, all of them, including me, we did very well in our degrees, that’s why we were immediately offered PhDs and later on positions and so on... Now no more, that has been diluted because Nepalese students are just working [in other forms of paid employment] and very many just come as if they are coming for money and not to study. That is not good. That is a later development.”

He also added that he thought the quality of those coming from Nepal had diminished, that in the past Nepali immigrants were “respected”, having come already with “a job and experience from Nepal”. Now, however, “anybody” was coming. This meant that fewer were getting “those kind of fellowships like before” and thus those Nepalis had to work in addition to support themselves, not doing well in their studies and hence “they do not have a good reputation like before”. Certainly I encountered Nepalis who were struggling with their studies in Norway. Arjun was one trying to balance work with study; his efforts to finish a (self-funded) Master’s degree while at the same time doing shiftwork as a kitchen assistant had left him perilously close to not completing the thesis component before his student visa expired. Meanwhile, Sanjay, although not working alongside studying, was, when we spoke, in the process of having

to resubmit an assignment, having failed it the first time round. He admitted that he found the work hard to keep up with.

Ravi focused on the more recent tendency of Nepalis to want to stay on in Norway. Whatever their reason for coming (for study, accompanying family members or in search of work), “most people like to remain, even the students, they try different ways to extend their education”. Again, he identified the higher salaries available in Norway as a primary motivating factor, adding: “I expect more Nepalis to be coming [to Norway]”. This prolongation of study was something I became aware of among several of the Nepalis I encountered. In at least two of the married couples I got to know, the husband had undertaken a course in Norway, and near to finishing his studies, the wife had then secured a place to begin another course there. Elsewhere, another student, although officially finished with his Master’s course, was now taking “extra courses”. In another case, Sunil, who had just successfully completed his Master’s degree in Oslo, told me he was looking for a funded PhD position somewhere within Europe, actively considering Denmark and the UK alongside Norway in his search. Whether or not these were purely strategic efforts to stay in Norway, as opposed to reflections of personal wishes for educational advancement, for example, they demonstrate the ways in which Nepalis sought “to remain” (as many referred to it).

Their reliance on a (limited term) study permit was a source of worry to several of the Nepali students I met up with. As stated in Chapter 1, Norway has a reputation for strictly enforcing the law with regard to would-be immigrants, demanding that they fulfil specific registration requirements on arrival (iMDi 2016), and in some cases thereafter undergoing regular checks and reviews of their status, as for those on study permits (UDI 2016). During the time I worked with them, those such as Sanjay, Puja and Arjun, whose residency was based on their study permits, experienced several fraught months in the lead up to an attempted renewal or applications. Related to this concern was that of trying to find work. Talking with a group of male students, I learned of their “surprise” and frustration at coming across people from other countries in Europe (they mentioned Spain, Italy, France and Eastern Europe) who had come to Norway to get better paid equivalents of their jobs at home. One of the students, who at that time was finding it hard to secure any work at all, called the situation “unfair”, explaining that people coming from European countries were still better off than those coming from “poor countries like Nepal”. That said, they and many other Nepalis I met with admitted that learning Norwegian was a major obstacle to getting a ‘good’ job in Norway. Even the students who received free one-year intensive Norwegian language courses, as part of their studies to help them take Norwegian-medium courses, found the time insufficient and so opted for English-medium courses instead. As one man put it, “after all, I have been learning English since school

and I still find that difficult at times to understand!” Those outside the formal education system went to language classes run by specialist institutions, some subsidised, where they still found it hard. Pronunciation was apparently especially difficult. “In Nepali there is no difference between ‘sh’ and ‘s’”, explained Lalita, offering just one example of the problems a Nepali might encounter in learning Norwegian.

On the question of whether to remain in Norway or return to Nepal, Nirmala – born in Nepal but schooled since her teens in Norway and now (in her late twenties) working in the education sector – offered a particularly considered response. Her father had come to Norway as a PhD student in his thirties, bringing his family with him, yet had subsequently returned to Nepal with his wife. Nirmala had chosen to stay on. She thought that for those of her father’s age “probably with a good network and good job in Nepal to go back to” it would be easier to return and “much harder to stay in Norway”, where they would need to learn the language and get a job that is at least to the level of education that they have attained. In contrast, for “their kids” (like Nirmala) and “younger bachelors”, who were probably less well-established in Nepal or more willing to learn the new language, Nirmala reckoned there was “a greater chance and interest to stay”. And it was these types of people, she thought, based on those she knew, that made up the majority of Nepalis to have settled in Norway.

More generally, when asked how long they planned to stay in Norway, while some were clear about plans to return – “in two years”, “if opportunity [arises to remain in Norway] then planning to stay longer [than the duration of studies]... but not more than ten years because the social life is so good in Nepal” – several simply responded with “don’t know” or similarly circumspect answers. Nayan, for example, resident in Oslo for the past eight years and currently working within health-related research, thought that he and his wife and children might now stay in Norway “possibly life-long”. Reiterating Nirmala’s comments about connections, he thought he was now “better connected here [in Norway] than in Nepal” and that his chances of securing further work in Norway were good, whereas returning to Nepal he might probably have to “start from the bottom”. Among those more settled in Oslo, with ‘fixed’ jobs and their own homes, returning to Nepal once they had finished their working lives seemed a preferred potential option. “I don’t see my job in Nepal”, said Shanti, but regarding retirement, “I think Nepal would be the perfect place for us then”. Mira, Nirmala and Annie all expressed similar sentiments, adding that once their children had grown up and left home, they together with their husbands might consider returning to Nepal. These responses also convey a tendency that I detected on a more widespread level among the Nepalis I encountered: to differentiate between Norway as a land of economic advancement and opportunity, and Nepal as a kind of social base, to which several thought they might one day return ‘home’. This, in turn, raises interesting

questions about the ideologies of ‘home’, which feature to some degree in Chapter 4, in notions of food preferences and quality (the greater “tastiness” attested to by many of my respondents when speaking of Nepali meals and vegetables in comparison to western-style counterparts). However, a more in-depth focus on the issue is beyond the scope of this enquiry although definitely worthy of any future research with this group.

Middleclassness

“Nepalis who come to Norway are middle class”, Ravi stated during one of our many conversations. Although only one among the many Nepalis I worked with, Ravi’s representative position within Norway’s Nepali population gave him an important overview, which taken together with my own findings that almost all the Nepali adults I met with had completed school (most attending university as well), seemed to make his assertion more than likely. The term middle class is a complex one, including social, economic, educational, material, cultural and political factors. Moreover, as Donner and De Neve make clear, defining the position of the middle class within any given society rests on “a plurality of criteria” (skills, values, tastes, cultural traits, manners to name but a few) (2011: 6). Liechty, documenting the formation of a growing middle class in Nepal’s capital, Kathmandu, considered middle-class status to be more a process than a product, “a new sociocultural project” (2003: 61), rather than any objectively configured social group:

“The middle class [in Kathmandu] is a constantly renegotiated cultural space – a space of ideas, values, goods, practices, and embodied behaviours – in which the terms of inclusion and exclusion are endlessly tested, negotiated and confirmed”.

(Liechty 2003: 15 – 16)

This perception is shared by Donner in her evaluation of middle-class expression within Kolkatan households (2011), as well as by Staples who identified class as a “fluid social categorisation, performed as much as ascribed...learned, shaped and expressed through embodied action” during his work with people from poorer economic backgrounds in Andhra Pradesh (2014: 68 – 9). Using the expression ‘middleclassness’ rather than ‘middle-class’ is a useful way of conveying the dynamic nature of the category – positing individual location, while at the same time highlighting the ongoing reproduction of it through everyday practices, as well as its relationality and the tensions surrounding its boundaries and membership (Donner & De Neve 2011: 12).

Given its focus on Nepalis, Liechty’s work is especially relevant to my own, although there are also numerous parallels between his findings and those considering middleclassness elsewhere

in South Asia (for example, Donner 2011; Staples 2014). Concentrating on the rise of the middle class in Nepal, which is after all where all my adult informants were born and raised, most in urban or peri-urban settings, enables me to show why those I worked with in and around Oslo form part of this category. According to Liechty, the middle class began to emerge in Nepal after 1951, when the state began an “open door” policy, bringing about establishment of diplomatic missions in the capital, unregulated commodity imports as well as interstate relations (Liechty 2003: 47). The subsequent growth in government centralisation, trade, tourism and education led to the development of increasingly numerous and diverse tertiary sectors (clerical, technical, administrative etc.), together with shifts in occupational structures and the relatively increased flow of cash in exchange for work (rather than primary productive work), these all became key factors in the emergence of a middle class within Kathmandu (ibid: 47 – 51). Economic liberalisation and market reforms came later in India (in the early 1990s), but together with pre-existing (ongoing) technological and infrastructural developments, the country has undergone similar occupational and class shifts (Staples 2014).

The rise of class has brought about an apparent attenuation, at least to some degree, of caste identity, which was previously the ultimately defining factor within many South Asian socio-economic and cultural identities. That is not to say that caste is no longer relevant: in both Nepal and India, the social and economic elites remain disproportionately peopled by members of the higher castes (Donner 2011; Liechty 2003; Staples 2014). Yet caste is increasingly less likely “to guarantee (whether by privilege or exclusion) a person’s social standing” (Liechty 2003: 56). Instead new forms of identification, cultural practice and notions of privilege arise in the cash- and market-oriented economy (ibid). Consequently, Liechty argues, caste is effectively becoming more subordinate to class, class being the “framing paradigm” within which caste remains yet in competition with the “social imperatives” of the newer economic (money and market) drives (ibid: 8).

This project of middleclassness involves carving out a space, which, although not fixed, separates those occupying it from others either ‘above’ or ‘below’ (Liechty 2003; Staples 2014). These other classes serve as reference points against which the middle class can locate itself as such. Evident in Liechty’s research is the increasing prevalence of middle-class nuclear families in and around Kathmandu, a significant number first generation residents of the city (Liechty 2003). While, he contends, extended families may remain the ideal for most in Nepal, the lure (and relative abundance) of opportunities in the capital, and increasing levels of physical and social mobility related to this, has resulted in the migration of many middle-class Nepalis to the capital’s suburbs, and the establishment of increasing numbers of two-generation households there (ibid). None of the Nepalis I interviewed lived in multi-generational households. Nearly

all my respondents lived only with their spouse and any children; Sunil, a bachelor, lived in shared student accommodation. Parents and parents-in-law came to visit – sometimes for months at a time (see Chapter 6) – yet no expectation was expressed by my informants that they would come to live with them more permanently. We can now see that this also reflects the situation for many Nepalis living in Nepal, at least those in Kathmandu and – one could reasonably argue – other major cities, such as Pokhara, Patan and Biratnagar.

Liechty's work looks in detail at consumer practices and uses these as evidence and a chief index for the process and production of middle-class identity: "it is in the *practice* of consumer regimens (from "doing fashion" to restaurant going to watching videos "that the middle class *performs* its cultural existence, day by day" (ibid: 34 – author's emphases retained). And that in the new "democracy of goods", while caste status can still be a "good predictor" of class position and lifestyle, the altered economic climate enables those previously excluded from social and economic advancement due to low birth, "stories of low-caste taxi drivers with monthly incomes five times that of high-caste government officers abound" (ibid: 63 – 64).

However, Liechty also highlights the importance of education to definitions of middleclassness, which was a chief characteristic of the Nepalis I got to know in Norway and something evident elsewhere in South Asia (Caplan 1987; De Neve 2011; Donner 2011; Fuller & Narasimhan 2014; Staples 2014). For example, through their ongoing privileging of education and conscious efforts to reduce gender inequality (not least through increasing female education), Tamil Brahmins have consolidated their position among the Indian upper middle class, with higher educational qualifications and the professional or managerial positions these bring one means of differentiating themselves from the 'white collar' lower middle class (Fuller & Narasimhan 2014). Similar distinctions, and use of the term 'educated' as a synonym for middleclassness, were also found by Caplan, in his work with Indian Christians in Chennai (formerly Madras) (Caplan 1987). De Neve's work with the non-Brahmin caste of Gounder industrial capitalists resident in Tamil Nadu, meanwhile, showed that while economically successful and proud of their rural, uneducated roots and 'traditional' values, parents were now actively engaged in educating their offspring to help create a new middle-class identity for the group (De Neve 2011). Liechty made no particular distinctions between upper and lower middle classes in Nepal, and neither did the Nepalis I worked with in and around Oslo, nevertheless both our findings suggest the centrality of education within class definition for Nepalis.

As already mentioned, the overwhelming majority of Nepali adults I met came to Norway either to pursue (usually post-graduate) studies and/or to join their spouses who were engaged in this process. Those joining their spouses were often already graduates of Nepali higher education

institutions. Furthermore, prior to living in Norway, most had lived and worked in towns or cities. Concomitant with the rise of consumer opportunities and culture in Kathmandu, there has been a rapid growth in education provision, the great majority of further education institutions also located there (Liechty 2003). Outside of the capital as well, numerous development initiatives have been responsible for helping to instigate more widespread schooling across the country, those seeking to study at a higher level usually then migrating to Kathmandu (ibid). While education would not guarantee success, Liechty detected a firm belief among the middle-class parents that without it their offspring were unlikely to succeed in the “new labor and prestige market”, older forms of social capital (family connections, caste, for example) no longer the ‘given’ advantages they once were (ibid: 58). Education has thus become central “to the production and reproduction” of Kathmandu’s middle class (ibid).

Fashion and clothing were a major focus in Liechty’s research. While not at all what I concentrated on, it was nevertheless evident throughout my fieldwork that whenever I visited Nepalis at their homes or met with them outside, at cafes, lunch breaks from work, language classes (Puja and I met attending the same Norwegian course) or at the Nepali School (see below), they were wearing what I would describe as ‘typical’ western clothes. These clothes, moreover, seemed no different from those worn by native Norwegians, with the exception that I never encountered a Nepali girl or woman in a mini-skirt or mini-dress.¹² The wearing of western-style clothes by Nepalis began in the 19th century, adopted by the elites, who made it one of the exclusive markers of their status (ibid: 44 – 5; 119 – 20). However, with the aforementioned ‘opening up’ of Nepali in the 1950s, and growth of the middle class thereafter, western-style dress became an ever greater part of metropolitan Nepali life (ibid: 120 – 26). And while remaining strongly influenced by the Indian fashion market (ibid: 76), the ways in which clothing could signify connection to a more globalised, modern world, “a transnational fashioned class”, also played into Nepalis use of western-styles of dress (ibid: 139 – 40). The Nepalis I got to know, if men or boys, were usually wearing jeans or trousers and shirts, T-shirts and/or a pullover; girls or women, meanwhile, wore jeans or trousers (very seldom a skirt or

¹² Liechty records critical accounts, levelled by middle-class Nepalis, of those who wore ““short skirts, or short-sleeved shirts”” (2003: 75). They judged such revealing or immodest clothing as excessive (“immoderate”), identifying those who wore them – the moneyed elites, who could afford such international garments – as both vulgar and immoral (ibid). There was no obvious evidence of this attitude among the Nepalis I encountered in Norway, yet the evident lack of ‘revealing’ or ‘immodest’ dress among them could well speak to them holding similar views. The fact that for many months of the year Norway is very cold, much colder than many of the cities in Nepal, is not a sufficient reason to account for the consistently modest dress of the Nepalis I met, given that Norwegian women (and some men) wear physically revealing clothes year-round.

dress) and blouses or other tops, pullovers or cardigans. Foot attire in all instances comprised boots, trainers, shoes or sandals depending on the weather. The only exception was at festive occasions (for example, a wedding party, new year's celebrations) where some but by no means all of the women attendees wore *saris* or *kurtha* (long blouses), usually of colourful fabrics and intricately stitched, and some men would wear *Dhaka topi* (a patterned fabric hat, traditional in Nepal) atop regular-looking suits and open-necked shirts. In contrast, it was not uncommon for me to see older and middle-aged Pakistani women out and about in Oslo, food shopping for example, wearing *saris*, albeit often bolstered by jumpers, cardigans and coats against the cold; and for some time we also lived next to a Pakistani family, where the mother and grandmother both wore *saris* – yet the daughter, a student in her early twenties, I only ever saw in western-style clothes akin to her Norwegian peers.

Liechty detected a significant tension among many of his women informants in defining their and their families' middle-class status through what they wore: on the one hand being sufficiently 'modern' by wearing fashionable enough clothes to distinguish them from the lower classes, while on the other hand dressing in a way that was "somehow Nepali, or at least suitable to Nepali", which marked them from that tendency ("over style"), which they associated more with the upper classes (ibid: 75). My findings related to the clothing style of the Nepalis I worked with in Norway are limited to observations; it is nonetheless noteworthy that it never really surfaced as a topic of more general conversation when we met. There are several potential reasons for this: it was not my focus and the Nepalis I spoke with were usually aware of that, so were often keen to discuss the subjects they knew I was interested in; the high cost of living in Norway meant that clothes and material there are expensive, unlike in Nepal where it is readily affordable to most of the middle class to buy material and have clothes tailor-made (ibid); making clothes oneself was also affordable and common in Nepal, usually by women of the household, often without outside employment (ibid), yet most of the Nepali women I knew were working or studying in Norway, so had fewer resources – financial and time-wise – to devote to such efforts. However, from what I could perceive, the tension observed by Liechty was simply less apparent among the Nepalis I got to know in Oslo and Ås. In diaspora as they were, surrounded by other Nepalis of more-or-less the same Nepali (middle) class that they identified as, their task was seemingly not to differentiate themselves through clothing styles from other Nepalis, but rather to 'fit in' as well as they could with their Norwegian middle-class counterparts.

For its focus on Nepal and incisive delineation of the formation of the middle class there, Liechty's work forms an important basis for my own conclusions. Yet his emphasis is almost exclusively on consumption (mainly of fashion, film and youth culture) in the public sphere.

The significance of the domestic sphere, and of foodways within that, in building and sustaining middleclassness within the South Asian context, should not be overlooked (Donner 2011; Staples 2014). Class, as I shall now argue, is more than simply the sum of consumerist practices.

Based on their research in different parts of India, Donner and De Neve contend that making class distinctions “hinges on the reproduction of status within, and through, the domestic sphere” (2011: 14). Working elsewhere in India, Staples draws a similar conclusion: that eating habits and practices, and their shifting styles, are used to signify class and distinguish practitioners as being “more civilised and cultured than others” (2014: 80), “the emergence of new foods and tastes, ripe for symbolic appropriation” by those aspiring to middleclassness (ibid: 67). That this pertains within (as well as outside) the home makes sense; the numerous occurrences within any given day of home-based food preparation and eating events make households a highly significant site for “middle class socialisation” through foodways (Donner 2008a: 144). Food practices within various South Asian middle-class settings were, in the past, most strongly dictated by caste-based rules of commensality (Donner 2011). More recently (and increasingly), however, they are influenced by the aforementioned social and economic changes, which are an important means of confirming a sense of belonging as well as of maintaining boundaries (ibid); another way for people to differentiate themselves from, as already discussed, those ‘above’ and ‘below’ them. Moreover, to be middle class can also imply “an active appropriation of cosmopolitan, and largely global, food practices” (ibid: 64). This is reflected in my own research, where (as will be seen in the coming chapter) the Nepalis I worked with in Norway used food and related technologies and techniques in common with each other and their Norwegian peers, while at the same time retaining certain Nepali characteristics.

Within South Asian society there is an ongoing reformulation of public and private lives in search of a middle-class persona, a conscious balancing act between the ‘traditional’ and the ‘modern’. With specific reference to India, Donner and De Neve refer to it as trying to create “suitably modern, traditionally Indian ways of being in the world” (2011: 14), in Nepal, it is to be “Suitably Modern”, the title of Liechty’s book (2003). Furthermore, the greatest share of responsibility for this balancing act, at least within the domestic sphere, falls to the adult women of the household (Caplan 2002; Donner 2008a, 2011; Donner & De Neve 2011). In Calcutta, Donner has shown how ‘food work’ has become a defining feature of middle-class identity for women and their families, part of the devotion the women show to the domestic sphere: “the orientation towards home” (2011: 14 – 15). In practice this means women, the vast majority of whom stop working after having children, spend upwards of four hours a day in selecting,

preparing and serving food to their families (ibid). And even among the middle-class Bengali diaspora community in the US, where many women continue to work (albeit often part-time), several hours of the woman's day are spent doing this 'food work', women there remaining almost exclusively in charge of household catering matters (Ray 2004). Donner thus came to identify the stay-at-home mothers with whom she worked as "the backbone" of the middle-class cultural project, at least within the home (Donner 2011: 48). The food they produced was *carefully* prepared daily, seen as safe/hygienic (in contrast to the food from outside), could still correspond to any caste-based principles, and yet incorporated or responded to the tastes and preferences of children and husbands – tastes that were, in part, shaped by the burgeoning awareness and absorption of knowledge about the 'cosmopolitan' foodstuffs that identified their consumers as aspirant and middle class (Donner 2011). Caplan's (2002) work in Chennai yielded similar findings. Both authors moreover show that middle-class women used foodways-related strategies to further uphold the honour of the family, notably practising vegetarianism themselves, which although associated with longstanding caste-based links also spoke to notions of feminine sexuality (meat and other 'heating' substances, such as eggs, held to be necessary for male virility but provocative of sexual insatiability in women, hence dishonourable for them and their families) (Caplan 2002, 2008; Donner 2008a, 2011). However, this vegetarianism (not expected of the males or girls within the family) was newly configured within performances of middleclassness, as a membership and boundary ascribing behavior that helped to define the practitioner's middleclassness while also aiding ongoing efforts to balance 'tradition' and 'modernity', and hence maintain the virtue of the household (ibid).

During my own fieldwork I came across a few examples of women, all mothers who had finished their childbearing, fasting for the wellbeing of their male kin – usually by foregoing meat for a given period of time, often in conjunction with a Hindu festival. However, they all also admitted to being otherwise not especially observant religious practitioners and that this was very much something they chose to do, rather than feeling any external pressure. There was also the case with Indira, who during the course of my research decided to stop eating pork, something she had previously been doing. This was, apparently, a return to more formal rules associated with her high caste, yet it was a personal choice – she continued to prepare pork-containing foods for her three children and husband (also of the same caste), who told me that while he respected her wishes he had no intention of following suit. Sonya, meanwhile, offered a rather more pragmatic explanation for her near-vegetarianism (she still ate meat occasionally). Married to a Norwegian and with one child, she would prepare meat for them but was not so fond of the taste herself, and found it less easy to digest than vegetable and pulse-based foods, so would eat those instead. Thus we can draw some parallels between the practices described by Donner and Caplan above and those I encountered among Nepalis in and around Oslo but also

nuanced differences. Ray's work (2004), while useful as a comparator in many ways, considering as it does another middle-class South Asian group in diaspora, in this case is less helpful. Bengalis, even those of the highest, Brahmin caste are rarely vegetarian, moreover he makes no mention of fasting habits amongst his US-based Bengali informants (ibid). That said, fish was the animal protein mainstay for the first generation individuals he encountered, and he noted that the US-Bengalis would often define their "culinary Bengaliness" in positive opposition to American dietary habits and practices, the host nation's appetite for red meat in particular frequently derided, both the quantities cooked but also forms available (hamburgers and hot dogs the predominant examples) (ibid: 79). As already stated, the Nepalis I worked with were otherwise quite similar to the Bengalis Ray encountered in the US – also first generation, highly-educated (both men and women), middle class, and many with professional qualifications, even if in Norway these had only translated for some into equivalent jobs.

Looking more closely at the issue of gender parity, we see that the Nepali women I encountered demonstrated both similarities to as well as differences from other South Asian groups, whether in diaspora or not. For example, there were some particular parallels between my female respondents and those of Ray, whom he discovered were highly educated yet often "underemployed", having "jobs" rather than pursuing "careers" – partly through a choice to focus on childrearing, yet also driven by "insider expectations" of a mother's role (2004: 115 – 6). I too found some Nepali women in similar positions: Indira had qualified in a profession back in Kathmandu but worked as a health care assistant in Oslo; Maya gained a medical degree before coming to Norway, yet also worked now as health care assistant; and Parvati too had qualified in a highly-competitive profession but since coming to Norway had stayed at home, taking care of the household. Shanti, however, made active use of her Master's degree in a full-time position at a private-sector company, Annie retained her role as a nurse, and Sonya also worked as a professional in a large Oslo-based company. Overall, among the Nepali women I met, nearly all were either working or studying, whether or not they had children. There could be a number of reasons for this.

In Norway, *likestilling* (Nor: 'same position', often translated as 'equality') between genders is a concept that was legally enshrined there in the late 1970s, following passage of the *Lov om likestilling mellom kjønnene (Likestillingsloven)* [Nor: Law on Gender Equality (Equality Act)] (1978), and has since become a socially established norm. Both parents are expected to contribute actively to childrearing as well as working, and the state makes considerable efforts to support this stance. Shared, paid parental leave in the year following the birth of children was

usual among many couples.¹³ Moreover, the comprehensive availability, social acceptedness and relative affordability of the *barnehage* (Nor: kindergarten) system within Norwegian society enables both parents, even those on low incomes, to work full-time well before their children reach school age (seven years old, in Norway). While similar notions of gender equality may exist in the US, for example, I can find no evidence of like-levels of state support for and encouragement of organised childcare.

As Ray (2004), Donner (2008a, 2011) and Caplan (2008) make clear, among South Asian middle-class households there exists the expectation that raising children is the role of the mother, and among middle-class Nepalis living in Nepal, or potentially in diaspora, this could also be assumed to be the case. However, as Chapter 4 shows, among those I met in and around Oslo, the Norwegian norms of children attending *barnehage* and women working, even if not at the level they were originally trained (and even if they do), seem to pertain. And this is despite the added challenge of language, for nearly every Nepali woman I met now working in Norway used Norwegian in her job. Overall, the way in which the Nepali women and men I met balanced work and family-related commitments reflects, I would suggest, a combination of material realities (the high cost of living yet the accessible provision of childcare) and negotiation of the local (Norwegian) gender political climate with more traditionally held views of women's roles within the family – something which they, as members of the educated, middle class (both in Nepal and now in Norway) were well-placed to do.

Middleclassness in Norway

As the above suggests, since the 1970s, backed by legal and political will as well as an increasingly strong economy, Norway has developed a comprehensive state welfare system, part of which is an explicit policy to help parents balance the demands of work and family life, consciously enabling a very high female participation in the labour market (Angell 2008). Concomitantly there has been a decline in the number of industrial working class and increase in part-time work has led to a fragmentation of the working class more generally (Repstad 2008). At the same time, the middle class has expanded, “both objectively and on the level subjective class identification”, leading to a so-called “one-plus-eight-plus-one society”,

¹³ The overall period of paid parental leave possible is 49 weeks at 100 percent salary of whichever parent is on leave, or 59 weeks at 80 percent salary. Three of those weeks can only be taken before the birth of the child(ren) and the woman bearing the child must take the first 6 weeks. As an added incentive, to encourage men to participate, each parent has a quota of 10 weeks that can only be used by them and if not taken is forfeited. The remaining 26 or 36 weeks (depending on whether the parental leave is taken at 80% or 100% payment of usual salary) can be divided as the parents wish, with whoever is not working during that time being paid the relevant percentage of their usual wage (NAV 2013).

whereby the significant majority can be described as middle class (ibid: 175 – 76). Against this backdrop of the prevalence of middle-class status within Norway, I would suggest that it was fairly straightforward for the Nepali immigrants I encountered to see themselves as middle class there too. Aside from the aforementioned and by-now-fairly-longstanding existence of a middle class within Nepali society, most of the Nepalis I met in Oslo or Ås were not only educated to a post-school level but they were also in receipt either of good salaries or adequate funding for their studies. And among those that were not, self-supporting students in the main, they still seemed to manage a reasonable standard of living.

Exploration of more specific cultural markers of Norwegian middleclassness are beyond the scope of this thesis – and not, I would argue, relevant to the point being made just above: that the Nepalis I got to know were able to fit relatively comfortably into the Norwegian middle class, as socio-economically defined. Nevertheless, a brief examination of research conducted by Norway’s National Institute for Consumer Research (SIFO, *Statens institutt for forbruksforskning*) across the four Nordic nations – Norway, Sweden, Finland and Denmark – reveals particular foodways-related patterns common to most Norwegian households (Kjærnes 2001). And given that, as we have seen, most Norwegian households (eighty percent) could be defined as middle class, Kjærnes’s (2001) Norway-specific findings can be read as a description of middle-class foodways there. Thus in Norway breakfast was usually a cold meal, comprising open sandwiches, coffee, tea and/or milk (ibid). During weekdays, lunch followed a very similar pattern, again open sandwiches eaten at the place of work or study (ibid). The evening meal, usually served between 4 – 5pm, was the main hot meal of the day, most often eaten at home with other family members if they were present (ibid). The meal itself was simple in structure, typically one course, usually of meat or fish, together with vegetables and potatoes, although sometimes followed by a simple dessert, “mainly fruit or ice-cream” (ibid: 14). The proportion and variety of vegetables present was notably limited, “about one third of all hot meals included carrots”, boiling a favoured means of preparing them (ibid: 15). As will be seen, Chapter 4 shows that this description fits well with the characterisation by some of the Nepalis I met of Norwegian food as bland, both in flavour and with regard to the vegetables used. Furthermore, it will be seen that there was a observable variation in the usual timing and content of the evening meal – which was often Nepali in style and eaten slightly later than in a typically Norwegian household.

Despite a noted political commitment in Norway to gender equality, the majority of ‘food work’ in the home was still done by women although it was recorded that there was a shift towards more division of such labour, “most visibly among the young and among those with middle and higher occupational status” (ibid: 21). The extent to which being middle class itself is enacted

by Norwegians through these particular dietary habits and practices is not specifically addressed, however the evident uniformity of meal contents and timings points to the possible production and reproduction of ways of being that might well contribute to a Norwegian sense of being middle class.

The Nepali School

Outside of the culinary sphere, another place where I glimpsed possible signs of the balancing act my Nepali respondents were negotiating, between Nepali and Norwegian expressions of middleclassness, was at ‘The Nepali School’, which I visited regularly during fieldwork. Based at a community centre serving one of the outer suburbs of Oslo, it had started running in August 2013 and opened one evening a week, 5:30 – 7:30pm, during school term times. Ravi was the major force behind its founding, and his wife, Indira, and a group of friends and colleagues – and their children – now formed the core of the staff and students. The inspiration had come from a meeting Ravi had attended, where he learned of a ‘Tamil school’ run by Sri Lankan immigrants living in Oslo. Established several years earlier by members of the Tamil community, Ravi explained, it provided “language and culture lessons” to Tamil children now growing up in Norway. A volunteer-run, after-school organisation, its remit had now expanded further, offering other forms of tutoring as well, in mathematics for example. Ravi was inspired to start something similar among the Nepali people living in Oslo.

Few of the Nepali children and adolescents I met during fieldwork had any experience of being schooled in Nepal (most having been born in Norway). Although often understanding and in some cases speaking Nepali, they were usually unable to read or write it. This was something several of their parents expressed regret about to me, Ravi included. Hence the Nepali School sought to try to address this. The three female teachers, Annie, Indira and Mira (none of whom usually worked as teachers, but who were all mothers of students), instructed their charges in the Nepali alphabet and writing, using textbooks brought back with them from trips to Nepal. Devi, father to one of the students, played the guitar and sometimes taught Nepali folk songs to the children as well I was told, although I never witnessed him teaching. Sessions (the evening was divided into two parts, with a short break in the middle) were also given over to teaching traditional Nepali dances, again taught by one of the mothers as well as a couple of Nepalis in their late teens/early twenties, who were keen dancers and interested to help. The hope was that the children would then perform at Nepali festivals, something I saw happen (to the evident pleasure of the audience) when I attended the Non-Resident Nepali Association (NRNA) Oslo New Year celebrations the following year.

When the Nepali School first began there were “about ten pupils”, Ravi told me, yet this had soon dropped to the steady seven or eight who I would see each time I went along. Their ages ranged from six to twelve, all taught as one class, which, taken together with the differing degrees to which Nepali was used at home, made for a rather mixed ability group. The teachers tried to take turns, although shift work for two of them (one a nurse, the other a health-care assistant) meant that this was not always possible. While the class took place in one part of the centre, the parents who had brought their children along usually hung out together in an adjacent room. The atmosphere among the adults was light and friendly: speaking to one another in Nepali, everyone seemed to know each other well. Some of the men would play pool or chess, others (male and female) simply chatted, the topic of Nepali politics a popular one for many.¹⁴ (Another time Ravi would tell me that more generally in Nepal politics and the political issues were the stuff of daily conversation, “what we chat about over tea with each other,” he said, likening it to the way Norwegians talk about the weather). Furthermore, I noticed that Nepalis living nearby who had no children, whose children were too young to attend, or who were on a visit from Nepal and staying with relatives in Oslo, would also sometimes drop in, simply to join in the social gathering. The Nepali School had been conceived as a place to disseminate knowledge about Nepali cultural practices among children now growing up (outside of their homes and close friendship networks) in a largely non-Nepali setting. However, it came to function more broadly, as a regular means for Nepalis of any age living in Oslo to connect with each other. Witnessing the activities of the Nepali School therefore offered me further insights into the efforts made by Nepali immigrants living in Oslo to convey elements of their pre-existing Nepali middleclassness – principally the importance of certain cultural practices but also socialisation within a particular Nepali milieu – while at the same time expressing typically Norwegian middle-class norms, through the western-style dress (worn by everyone I ever saw there), as well as the timing of the sessions (following a usual Norwegian evening meal time of 4 – 5pm).

¹⁴ As I got to know more Nepalis, the extent of their political engagement became ever more apparent. Many told me how they used the internet to keep up to date with Nepali news, politics especially. At the time of fieldwork, politicians in Nepal were debating enactment of a (much delayed) new political constitution for the country following the preceding decades of civil war. The scale of interest was such that a specific seminar on the topic took place in Oslo, to which I went along. ‘Nepal – a democracy in progress’, (08.02.2014) was jointly arranged by the NRNA and the NNF (*Norge-Nepal Foregningen* [Nor: Norway-Nepal Association]). A day-long event, featuring speakers from Nepal and Norway who analysed the political situation there, it was attended by around over 50 people, about half of them Nepali.

Discussion

The Nepalis I worked with in Norway demonstrate certain differences, in terms of foodways and middleclassness, when considered alongside other studies of South Asians. My Nepali respondents middleclassness is less clearly articulated through their dietary habits and practices as compared with their middle-class contemporaries living in Kolkata. Moreover, the Nepali families' middle-class identity seemed considerably less tethered to the 'food work' of Nepali women, at least as far as I could discern (the fact that the Nepali men also took an active, if variable, part in food preparation, was significant in this regard). Nevertheless, akin to the US-based Bengalis studied by Ray (2004), the Nepalis in and around Oslo that I encountered were responding to the more typical food patterns of the host nation, at least for breakfast and lunch yet sometimes also 'mixing it up' in evening or weekend meals, incorporating more typically 'western' foods such as pizza, pasta, sausages and other forms of meat. And as Liechty has shown, Nepalis living in urban settings have been steeped in patterns of middle-class consumerism for many years.

Given that nearly all of the Nepalis I met were raised or had lived in cities in Nepal before coming to Norway, it seems reasonable to suggest that upon arriving in the new country they already had some notion of how their middleclassness could be performed through food-related consumption practices. Once in Norway, even if not yet fluent in the Norwegian language, and already literate enough in the language and ways of food advertising, they could (and would) identify and eventually appropriate at least some of the dietary habits and practices considered middle class in their new home. At the same time, in common with Ray (2004) and in some ways Donner (2011), I found that by preserving most evening meals as Nepali in style, and hence as sites of and for the consolidation and reproduction of Nepaliness (see Chapter 4), the Nepalis I write of regularly reasserted their culinary traditions. Taken altogether, this suggests they were enacting a balance between, on the one hand 'fitting in' (in ways appropriate to their aspirations and their own ideas about what their social positions should be) in Norway, and retaining their Nepali identities – in this case through food – on the other.

There is also, I would suggest, a way in which activities at the Nepali School aided the gendered work of reproducing middleclassness referred to above. As already noted, the Nepalis I got to know in Oslo could be defined (by themselves as well as others) as middle class. Furthermore, the teachers at the Nepali School were almost exclusively female, and all of them mothers. Over the months I attended, I never saw Devi, the musician and father to one of the pupils, teach, and the male dance instructor, who came only intermittently, had no offspring. Parallels are therefore present between the findings of Donner (2011) and Caplan (2002), who, as discussed, showed middle-class mothers to be the main figures responsible for balancing 'traditional' and

‘modern’ values within the household, through the medium of food. I would argue that there are evident similarities to this, this time in diaspora, outside of the home and through non-foodways-related means: that the Nepali middle-class mothers, as the main teachers of other cultural practices (language, dance), are still engaged in the project of balancing ‘modern’ and ‘traditional’ values in a way that is coherent with middle-class values already well-established within Nepal (Liechty 2003) and India (Caplan 2002; Donner 2011).

As already mentioned in relation to clothing, this ‘fitting in’ takes on new dimensions in a diaspora setting. Performing middleclassness in Nepal – be it through dress style or food – meant distinguishing oneself from other Nepalis, either ‘above’ or ‘below’ in class. In Norway, however, Nepalis were more-or-less of the same, middle, class. Being recognisably ‘modern’ and middle class while living in Norway therefore required emphases of slightly different kinds. In terms of food, work and home-life, this meant eating breakfasts and lunches, and the occasional dinner, similar to those typical of the host nation, both men and women otherwise working or studying and any children attending kindergarten or school. Clothing, meanwhile, involved wearing overwhelmingly western-style clothes, largely the same as worn by Norwegians (the majority of whom, as we have seen, might be defined as middle class). Yet there were specific, albeit flexible, times (evening meals) and places (the home, festive events) where observance of particular Nepali practices and styles occurred. These temporal and physical spaces, moreover, offered the potential for performing middleclassness along more typically Nepali lines, for example when preparing Nepali meals from scratch, when women family members fasted or avoided certain foodstuffs, or the wearing of fashionable yet appropriately modest Nepali- or western-style clothes. Thus the Nepalis I encountered in Norway could be said to have been enacting middleclassness twice: in one way to ‘fit in’ with their ideas and aspirations for what they perceived their positions should be in the host nation, yet also by seeking to maintain the status they already identified with when coming from Nepal.

Looking towards the future it seems possible, probable even, that the Nepali middle class presence in Norway will increase, and with it new kinds of intra-group differentiation likely develop. Talking one afternoon with Ravi, he predicted that not only would more Nepalis be coming to Norway but that this would also lead to “increased factions”. He gave the example of some Nepalis who had moved to Portugal for several years, gaining a Portuguese passport and then moving on to Norway – “there are more than one hundred now in Oslo, they even have their own society, the Nepali-Portugal Society”.¹⁵ He went on to say that in countries with larger

¹⁵ While I have found no evidence of a society of this exact name, internet searches have revealed reference to (although no specific website for) a ‘Portugal Nepal Friendship Association’. (See, for

Nepali diaspora populations he knew of groups coalescing “around town or ethnicity: people from Pokhara, or Gurungs”. There was also the apparent potential for “factions” based on “political preferences”, he added. This process of fragmentation or disaggregation is perhaps an inevitable consequence of greater numbers, the simple fact of being Nepali no longer necessary to unite individuals; that at some point when there are enough Nepalis overall, more specific alliances could emerge, potentially more reflective of those already existing back in Nepal (along ethnic or political lines, for example). Thus while at the time of fieldwork the Nepalis I encountered as well as the NRNA presented the impression that identifying as Nepali was an effective unifying measure – those from different towns, of different ethnicities or castes and of differing political persuasions appearing to socialise easily and regularly together – this looked set to change.

Conclusion

Connections between Nepal and Norway have existed for many decades, Nepali students a small but longstanding presence within Norway during that time. While once almost all were short-term visitors, present for part of their studies, this is now changing as ever greater numbers come, first as students (now often for an entire course), then seeking to ‘stay on’ if at all possible. And a small but likely growing number have succeeded; those who have settled, the ones with ‘fixed’ (i.e. permanent or semi-permanent) jobs. Now living in Norway they could be regarded in Norwegian terms as middle class – in all the married couples I encountered both husband and wife were working (the one exception was a newly-married woman, who had only arrived from Nepal a couple of months before). And where the couple were both Nepali at least one usually held a professional position (academic, nurse, doctor, engineer, just some of the examples). Furthermore, as will be seen, they were ready users of childcare services made available by the state (Chapter 4) as well as biomedical support during pregnancy and childbirth (Chapter 6). This connotes usual middle-class behaviour in Norway, while reliance on biomedical care is at least indicative of ‘modernity’ and middleclassness among Nepalis, as well as other South Asians (see, for example: Donner 2008b; Staples 2012).

The Nepalis I worked with were, however, already also middle class in Nepali terms. Middle-class identity, the project of becoming and maintaining middleclassness and how the balancing of ‘traditional’ and ‘modern’ values has manifested in Nepal and India, as well as among diaspora Bengalis in the US, have all been considered in some detail here. As a result, I have

example: <http://www.somnathsapkota.com/about/>;

<http://www.nepalembassyparis.gov.np/en/2013/04/22/news/64th-diplomatic-relation-between-nepal-and-france/33/>).

been able to suggest ways in which Nepali immigrants in Ås and Oslo sought to maintain their middleclassness. By balancing their modern work-life patterns with continued attention to more traditional elements – the adaptation of certain foodways, the clothing they wore, and in efforts to improve their children’s Nepali language skills – they remain recognisably middle class to themselves as well as to outsiders.

Establishing the middleclassness of the Nepalis I worked with in Norway is important. It will help us make better sense of their dietary habits and practices in relation both to health (Chapter 4) and to childbearing (Chapter 6), which are henceforth the main subjects of this thesis.

However, making clear the class status of my respondents also serves as a significant basis from which to build my first key argument of this thesis – the need to disaggregate the category of ‘South Asian’ – which as the introductory chapter has suggested, and the coming one will show, is currently used in an homogenising way within Norwegian public health discourse. As we have seen here, the different circumstances for migration, as well as original geographic, educational and especially class backgrounds between Pakistanis and Nepalis now living in Norway, already indicate that the classification ‘South Asian’ is an overgeneralisation. And Chapters 4 and 6 will demonstrate further how potentially effacing of significant differences such an overarching term can be, and thus the necessity of identifying differences such as class status between apparently similar groups.

Chapter 3 – ‘Cracking Codes’: Norwegian Public Health Attitudes towards South Asian Immigrants’ Health

In considering the experiences and views of the Nepalis I encountered now dwelling in Norway, I have also engaged with Norwegian public health studies, state-endorsed publications, as well as two Norway-based theses on South Asian eating habits and practices. Analysing this biomedical literature on South Asian foodways in Norway contextualises the public health 'climate' in which these Nepalis live, one that potentially shapes and impinges on their lives in various ways. While differing in style and sometimes tone, a common theme emerges across all the texts I examined, firmly rooted within the biomedical paradigm hegemonic within Norway. This is that South Asians are especially prone to certain chronic health problems (diabetes, cardiovascular disease, obesity) and that their foodways in diaspora are partly to blame. Accepting that cultural practices inform their eating habits, several of the authors thus present these cultural practices of the groups as something akin to codes that once 'cracked' can then be used as potential instruments through which to enable South Asians towards more 'healthy' foodways, in line with those advocated by Norwegian public health research.

The next chapter will outline the foodways and interrelated health beliefs of the Nepalis I worked with in Norway. This chapter concentrates on how Norwegian public health writers and institutions frame the issue of health among the nation's South Asian immigrant population more broadly, enabling me in the subsequent chapter to draw out the differences evident among the Nepalis I worked with, and to reflect on what the significance of these might be. Through its course, this chapter demonstrates that existing Norwegian public health research attitudes apply a biomedical frame that 'lumps together' highly diverse South Asian peoples, readily attributing 'unhealthy' practices within a group to 'culture'. As already mentioned, via application of a narrow biomedical gaze, efforts are then focused on harnessing such cultural knowledge towards public health ends. The potential implications of such an approach are several and negative. Firstly, it is not only overgeneralising, but also produces inaccurate data that could, in turn, have significant impacts on any health programmes developed as well as the potential for them to be successful (as defined within their own terms). Quite apart from this, associating 'culture' with blame and attempting to apply such crudely overarching assumptions (and then seeking to instrumentalise findings based upon them), displays a marked insensitivity towards cultural differences – something that an anthropological enquiry such as this one is well placed to identify.

In setting the scene against which my own ethnographic data and analysis can be read, this chapter also speaks in part to at least two of the key arguments put forward in this thesis.

Most obviously, with reference to the second argument, it makes plain the dominance within official research and guidance of biomedical models of nutrition in relation to evaluations of health and wellbeing within Norway. The more nuanced views of foodways and notions of health and wellbeing revealed by the Nepalis I encountered, which is subsequently discussed in Chapter 4, makes clear the problematically limited nature of this biomedical approach.

Secondly, the need to disaggregate the category ‘South Asian’, the first key argument and already established in the previous chapter, is again made apparent only this time by looking specifically at Norwegian public health research and its tendency to generalise from studies that focus mainly on Pakistani immigrants.

Norwegian public health research and concerns regarding South Asian immigrants’ health and their foodways

Rather than reiterate findings from the published research, here I will discuss how Norwegian public health writing acts to represent South Asian immigrants in a particular way – according to biomedical nutrition-related discourses – and thus to consider the implications of such an approach. As will be seen, especially in the Norwegian public health studies, South Asian immigrants, their foodways and lifestyle are presented in fairly reductive terms, judged more or less healthy according to Western scientific values. Correspondingly, behaviours or practices that fall outside of these, which in the case of immigrants are frequently attributed to their ‘culture’, need apparently to be identified so that they can be remedied (Helland-Kigen et al. 2013; Mellin-Olsen & Wandel 2005; Råberg Kjøllesdal et al. 2011; Wandel et al. 2008). In this case, the remedy would be changing the food practices of South Asians living in Norway so that they better corresponded with current nutritional theory and policy.

The implicit effect of enquiries and strategies aimed at changing habits and behaviours can often be to locate blame for the perceived health deficits within the ‘culture’ of the group in question. In countries such as Norway, where biomedicine is hegemonic, the dominant (Norwegian) cultural discourse presents the (idealised)¹⁶ health-related foodways in nutritional terms. Accordingly, these can come to be presented – via expert-led strategies such as dietary counselling (Mellin-Olsen & Wandel 2005) and regular, monitored meetings focused on diet and exercise (Helland-Kigen et al. 2013; Råberg Kjøllesdal et al. 2011) – as superior to those of the newcomers. However, anthropologists have long shown that the term ‘culture’ brings with it all sorts of problems and complications, a by-now well-worn path within the discipline

¹⁶ To what extent ethnic Norwegians adhere to dietary advice and guidelines promulgated by health agencies and personnel is, of course, open to question. A subject also worthy of research, it is however beyond the scope of this enquiry.

accounting for the indistinct nature of the word's meaning, yet its potentially essentialising and damaging effects (Farmer 1999; Geertz 1973; Hylland Eriksen 2001; Keesing & Strathern 1998; Ortner 1999). Neither a 'thing' nor intrinsically capable of 'doing' something, 'culture' has been defined as "a strategically useful abstraction from the distributed knowledge of individuals in communities" (Pool & Geissler 2005: 10). However, with few exceptions, the perception of 'culture' as a causative variable within the public health research discussed here remains prominent, and in the case of South Asian study subjects is perceived as having negative effects on their health. In fact, a persistent connection made by health professionals between 'culture' (used to connote negative difference) and poor health is well known (Farmer 1999; Staples 2012).

As already discussed in Chapter 1, migration is recognised to bring with it alterations in immigrant diets and eating habits, examples given of anthropological and sociological research into foodways of immigrants from Iran (Harbottle 2006), India (Homans 1983; Bradby 1997) and China (Wheeler & Tan 1983) who came to live in the UK, and from Bengal to the US (Ray 2004). Biomedical and nutritional research, a significant amount from Scandinavian or Scandinavia-based authors, has also focused on changes in dietary habits following migration, in common with the above anthropological studies identifying changes to diet content (Holmboe-Otteson & Wandel 2012), meal patterns in response to new working conditions/schedules (Koçtürk-Runefors 1991), the effect of scattered family members, and the role of children in driving change (for example, Mellin-Olsen & Wandel 2005; Wandel et al. 2008).

A major concern of biomedical and public health studies has been with the incidence and prevalence of cardiovascular disease and diabetes among certain immigrant groups – South Asians in particular – that are found to be higher than in the host nation's population (for example, see: Chowdhury et al. 2003; Fischbacher et al. 2007; Holmboe-Otteson & Wandel 2012; Stone et al. 2007; Tillin et al. 2005; Williams et al. 2011; and the PODOSA trial).¹⁷ The Norwegian researchers, Holmboe-Otteson & Wandel (2012), identified a general trend towards increased intake of fat, meat and dairy products, and reduced carbohydrate consumption (and within that a switch to more refined versions, decreasing the fibre content) in populations coming from lower income countries to settle in Western Europe. These changes in food habits are, in turn, implicated in the development of obesity, Type 2 diabetes, and cardiovascular disease, chronic diseases with notable burdens for the sufferer (morbidity and potential

¹⁷ PODOSA (Prevention of Diabetes and Obesity in South Asians) was a large-scale research project focused on Pakistanis and Indians living in Glasgow and Edinburgh. (Douglas et al. 2013)

mortality) and the state (escalating demand for health services). While such a ‘nutrition transition’, as it has been termed, may have been evident in the country of origin, the speed and scale of the shifts are significantly greater in the diaspora populations (ibid). Consequently, rooted firmly within a biomedical discourse of nutrition, health professionals in Europe and Scandinavia have sought to target these immigrant groups, South Asians in particular, in a bid to try and prevent “nutrition related diseases in these populations” (ibid).

In Norway, concern about the health of immigrants was made explicitly clear when the Folkehelseinstituttet (FHI) (Norwegian Institute of Public Health) launched the Oslo Immigrant Health Study (OIHS), in 2002. This followed on from a previous population-based study, The Oslo Health Study (HUBRO), run by the FHI from 2000 – 2001, in which more than 18,000 Norwegian-born individuals participated, filling in questionnaires about health, demographic information and lifestyle, and undergoing clinical screening. The aim was to “gain a comprehensive overview of the health status of Oslo residents”, providing “a good basis for future health planning and service delivery” but also a means “to clarify, describe and explain” variations in the health of residents and provide researchers with “new knowledge about health, disease and new trends” (FHI 2015). Following the same study protocol, the OIHS’s purpose might be assumed the same (although this is not entirely clear from the overview given) (FHI 2008). It focused on the five largest immigrant groups in Oslo, people coming from Turkey, Iran, Pakistan, Sri Lanka and Vietnam, a total number 3,726 people participating in the study (ibid). Again each person filled out a main and supplementary questionnaire seeking demographic, health, diet and lifestyle information, and underwent clinical screening that highlighted the measurement of potential markers of obesity, cardiovascular disease and diabetes.

As already noted, Pakistanis are currently one of the largest non-European immigrant groups in Norway,¹⁸ and are widely recognised (by the biomedical and public health communities there) as especially prone to developing obesity, Type 2 diabetes and cardiovascular disease (Holmboe-Otteson & Wandel 2012). As a group, and following the OIHS, they have therefore become a particular site of research and intervention in Norway. In Oslo, specific efforts have gone into ascertaining the effect on changes to food habits of socio-economic, demographic and

¹⁸ According to the most recently published official data, Norway had a population of approximately 5,214,000 (SSB 2016a). Pakistani immigrants and those Norwegian-born whose parents had migrated from Pakistan numbered 36,026 (ibid). According to this definition, the other largest non-European population were Somalis (40,100) and then Iraqis (31,490); Poland, Lithuania and Sweden were the three other (European) countries with greater immigrant populations in Norway: 105,725; 41,626; and 39,965, respectively (ibid). In comparison, the number from Nepal was 1,689 (ibid).

integration factors among Pakistani and Sri Lankan settlers (Wandel et al. 2008), and exploring the food perceptions (Råberg Kjøllestad et al. 2011) and changing food habits (Mellin-Olsen & Wandel 2005) of Pakistani women in particular. The stated objective of one study was to “explore food perceptions in terms of health among Pakistani immigrant women, and if such perceptions could be altered through a culturally adapted intervention” (Råberg Kjøllestad et al. 2011). Another asserted: “[E]fforts to prevent obesity, diabetes and CHD [coronary heart disease] through dietary improvements have to be culture sensitive and based on daily life to be effective” (Wandel et. al 2008, quoting Glanz, Rimer & Lewis 2002). And yet another concluded that “to facilitate compliance” with dietary counselling there is a “need for culturally specific approaches” given the influence on diet of “a multitude of culturally specific beliefs and attitudes” expressed in focus groups conducted with Pakistani women (Mellin-Olsen & Wandel 2005). Together, these excerpts suggest that the ‘culture’ of immigrants to Norway was a form to be ‘decoded’ sufficiently. This achieved, it could then be used instrumentally, as a medium through which state health authorities and practitioners might channel energies and education predicated on the (dominant-within-Norway) biomedical health beliefs and eating practices, to improve population health and reduce the incidence and prevalence of certain chronic diseases. Mellin-Olsen and Wandel, for example, are explicit about this: “some background knowledge [for western health personnel, in this case of non-biomedical articulations of hot/cold properties of foodstuffs] is important to be able to cooperate with women in order to create a common platform of knowledge in the search for appropriate foods” (Mellin-Olsen & Wandel 2005: 334). By “appropriate” we can assume they mean suitable according to the logic of nutrition.

This is, I accept, a rather critical reading, which risks accusations of excessive cultural relativism. It is, after all, acknowledged by elements within the public health profession that their relationship with the public they serve is ambiguous (agent of the state, yet also advocate for people’s health) and complex: health and health care are steeped in political and social practices; public health, meanwhile, is neither a unitary concept nor body of knowledge informed by a neutral evidence base (Green 2015). In the context of my research, the aforementioned authors are all skilled health professionals, working within an internationally-recognised biomedical public health paradigm. The studies seek largely to account for what changes have occurred following migration, not necessarily the specific meaning behind them. Moreover, the researchers are almost certainly acting in good faith, from the conviction that what they are seeking to do will help towards a healthier population. And South Asian immigrants to Oslo have been identified as particularly at risk compared with other groups and ethnic Norwegians: with the highest prevalence of obesity (Kumar et al. 2006), and at highest risk of developing Type 2 diabetes (Jenum et al. 2005). In addition, as public sector employees

tasked with responding to state concerns regarding health service provision, these researchers are also required to deliver their findings in particular quantifiable forms (for example, measurable behaviour outcomes), which are then legible to – and can interdigitate with – other facets of bureaucratic administration (welfare provision, pensions and taxation etc.). Participants in the studies themselves reportedly expressed concerns about health and the need for advice (Holmboe-Otteson & Wandel 2012). That said, it is possible that respondents may be supplying answers they think the questioner wants (Staples 2012, citing Hammersley & Atkinson 1995: 126 – 133), something I tried to remain mindful of throughout my own research. Nevertheless, public health information and interventions to reduce fat intake had apparently made an impact on Pakistani women living in Oslo. A three-stage process was identified by Mellin-Olsen and Wandel (2005), whereby on first moving to Norway, Pakistani women described increasing their use of butter and margarine due to taste preference, perceived higher status and relative cheapness. Then, acting on nutrition information received in Norway, they switched to preparing food more with oil, and now, due to a particular public health focus on obesity in the Pakistani community, they tried to reduce the amount of oil used. Concern about coronary heart disease was reported as a driving factor behind the changes (ibid: 331). Research assessing the effect of a targeted intervention – regular meetings where information was given about diet and exercise – on the understanding of diabetes among Pakistani women in Oslo of activity also demonstrated some apparent success (Råberg Kjøllesdal et al. 2011).

Study findings also suggested that some immigrants welcomed nutritional information and education. Given that the range of foods available differs fairly considerably from that in South Asia, with significantly more meat, fish, dairy and processed food products present in Norway, some study participants had expressed a need for guidance: “I feel that we do not have the knowledge we need. We do not know how to eat in this country” (Mellin-Olsen & Wandel 2005: 326). However, this perceived deficit in knowledge was tied to understandings of eating for health and wellbeing that were linked by the Pakistani women to climate and essential ‘hot’ and ‘cold’ qualities within foodstuffs. Thus study participants also described being able to eat *ghee* and meat (both considered ‘heating’) in Pakistan because they were able to “sweat” more readily (a ‘cooling’ action) due to the ambient temperature and potentially greater physical workload, whereas in Norway “you keep it [meat] inside you and turn out like me [overweight]”, or “here [Norway] they say that *ghee* gets deposited in the heart” (ibid: 328). However, despite acknowledging that “through discussions it became clear that sweating (through hot climate and hard work) was regarded as very important for good digestion”, the aforementioned reasoning by respondents about *ghee* and meat was dismissed by the authors as “misconceptions or myths about the effect of the climate on health” (ibid.). Similarly, regarding the three-stage model of change in fats use mentioned above, the authors found that “their [the

study participants’] final choice was often influenced by perceptions related to traditional medicine, particularly the hot/cold properties” (ibid: 331), making clear the significance of the women’s understandings of health that existed outside of a biomedical nutrition discourse. This unwaveringly nutritional gaze of the researchers, correct within its own terms, displayed notably little curiosity or apparent willingness to view participants’ ways of being more multi-dimensionally. Rather it reduced the women’s comments to this single paradigm (biomedical nutrition) and thus failed to acknowledge the breadth and complexity of dietary knowledge displayed by people drawing on alternative experiences of how to be healthy.

Limited engagement with the reasons behind certain dietary habits was also evident elsewhere. For example in observations that the main source of fats in Pakistani and Sri Lankan diets “were oil, meat, milk and milk products, and almost all the milk used was full fat milk” (Wandel et al. 2008: 383), the meaning of these foodstuffs beyond in purely nutritional terms is not obviously considered. While the remit for Wandel’s paper was ostensibly broad – to identify socio-cultural and demographic trends in the modification of food habits following migration – the conclusions drawn were resolutely related to nutritional notions of health: the findings apparently inferred “substantial health implications”, pointing to “very high total fat consumption” and “the decline of beans and lentils” despite their potentially “beneficial” role in diets aimed at reducing risk of diabetes (ibid: 384).

Two South Asian researchers have written theses specifically focused on diaspora foodways within South Asian groups now living in Norway. One, a Nepali, worked with Nepali immigrants (Malla 2005), the other, an Indian, did her research among Pakistanis (Dawes 2006). Both Master’s degree level and written within the last decade or so, their authors (both immigrants) studied either at nutrition- or public health-allied departments within Norwegian higher education institutions, and the conclusions offered in each work are, unsurprisingly, in keeping with the aforementioned biomedical and public health-based logic and rhetoric. That said, both works offer useful, disaggregated insights into a particular South Asian groups’ foodways, against which my own findings can be read. The study by Malla (2005), moreover, was especially relevant, focusing as it did on Nepalis living in Norway. In the next two sections, I shall therefore examine these studies in more detail.

‘Changes of food behaviour among Nepalese migrants living in Norway: A qualitative study’ (Malla 2005)

A Nepali immigrant to Norway herself, Malla (2005) investigated how “food behaviour” had changed among Nepalis who had migrated there. To date her work is the only one I am aware of relating directly to foodways among Nepalis living in Norway. A qualitative study, grounded in

nutritional science, it used semi-structured interviewing to gather data. Although she did acknowledge the significance of economic and socio-cultural factors in shaping foodways, Malla's own framing and discussion of health and foods was largely biomedical. The evident nature of her nutrition/public health-based focus is perhaps most effectively captured in her concluding comments: firstly, that her work could "assist dieticians who work with Nepalese migrants to plan an acceptable diet and provide appropriate nutrition counselling for their clients, in case they become hospitalised and sick" (ibid: 85); and secondly, owing to increasing migration of Nepalis to Norway further studies would be needed "to assess changes in food consumption and any relationships to weight status and possibly chronic diseases risk factor among both sexes in children and adults" (ibid: 86). Conscious of its particular disciplinary bias, as well as the limits to which such a relatively small study's findings can be generalised (something Malla fully acknowledged), her research nonetheless provides a significant reference point for my own work.

Malla's facility with the Nepali language and 'insider' status enabled her to gain quite detailed information from each of her fifteen interviewees, all of whom were women resident in Norway for at least one year. Conducted in Oslo, Ås and the city of Tromsø (where Malla also had contacts), she investigated how food habits had changed following migration, factors that influenced food choice and adaptation of preferences, and perceptions of their 'new' diet with regard to health. From the results she was able to record and present certain patterns evident in the changed foodways of the Nepalis now they lived in Norway. Malla made extensive use of Koctürk-Runefors' (1991) model of adaptation to interpret her findings (see Appendix D), concluding that her own results reflected the model well (Malla 2005: 77-78). Switches in so-called 'accessory foods' (drinks, sweets, fats, fruits, nuts and spices) from Nepali style to Norwegian equivalents were noted to become part of her interviewees' regular diet much more easily and earlier following migration than the 'staple foods' (rice, bread, pasta and potatoes), which in Nepal consist of rice and *roti* [an unleavened flat-bread] yet in Norway are bread and potatoes. In between, similar 'complementary foods' (legumes, vegetables, milk and cheese, meat, fish and eggs) continued to be consumed, although there were changes in frequency: a relative increase in meat consumption, and falls in the amount of eggs, legumes and vegetables eaten – echoing, as the next chapter shows, several of my own findings, as well as the comments of a prominent public health researcher in Norway who I interviewed, and which are discussed a little further below.

Among Malla's interviewees in employment, there was a substantial shift over to Norwegian-style cold, bread-based breakfasts and lunches, while the (two) women without jobs maintained more Nepali habits, including a warm, rice- or *roti*-based lunch. Dinner and certain weekend

meals, however, were largely Nepali-style for everyone she spoke with and usually eaten together with all the household members and sometimes friends as well. As will be seen was the case in my research, so the major shift for all of Malla's working interviewees was also from two, warm rice-based meals a day (lunch and dinner) to only one, usually the evening meal. Principal factors influencing what foods the women chose to eat were time (for food preparation), availability of ingredients and taste preference – time suggested as the most important, not least for structuring meals. The quick-to-put-together breakfast and lunches typical in Norway rapidly superseded the time-consuming preparation and cooking of a warm lunch as would have been usual in Nepal. Reduced availability in Norway of certain vegetables and legumes that Malla's informants would have used in Nepal also led to some substitution with meat, fish and fruits. The lack of certain ingredients, specifically the same abundance of fresh vegetables, led some interviewees to express a degree of dissatisfaction with their new diets, although the (relatively) lower price of fruits and assured food-hygiene standards in Norway were viewed positively. And while most of the women said there were elements in a Nepali diet that they still preferred, notably warm lunches, a pragmatic attitude prevailed: “In Nepal, we always eat warm lunch. There are no families who eat cold lunch. Lunch is always cooked and eaten warm. Here in Europe there's no time to make warm lunch so I am compelled to have cold foods”, one interviewee's comment (ibid: 70). This pragmatism was also evident in the substitutions of other ingredients, for example frozen and dried vegetables (brought back from visits to Nepal) instead of the “fresh and green leafy vegetables” they would have used back in their ‘home’ country (ibid).

Ten or so years on, the findings from my own enquiries into the general foodways of the Nepalis I worked with were markedly similar to those presented by Malla (see Chapter 4). My research, however, addressed more specifically my respondents' perceptions of wellbeing in relation to their foodways. Part of Malla's work also considered the topic, with her interviewees being asked for their views on a healthy diet and how their own practices related to this. Their responses were interesting for indicating the alternative interpretations they made of the term ‘healthy’. Approximately half (eight) are reported to have spoken in terms of a “balanced diet”, and that “a healthy diet consists of appropriate portion of carbohydrate, protein, different types of vitamins, less fat and salt” (ibid: 73). Moreover, these women considered the Nepali diet “fatty and salty as they [Nepalis] used lots of oil, *ghee* and salt in cooking”, and judged their ‘new’ more Norwegian food habits (“less salt, less fat and less carbohydrates”) as “much healthier” than what they had previously eaten in Nepal (ibid). In addition, feeling “heavy” and “sleepy” – as with my respondents, not considered intrinsically negative qualities but usually undesirable during the day – were associated with Nepali meals but not with the Norwegian ones (ibid).

Again, in common with several of the Nepalis I worked with, Malla's remaining seven interviewees judged health more in terms of food hygiene and safety, "that a healthy diet is a diet that people do not get sick after having it [sic.] as well as free from bacteria and mould" (ibid: 74). Recalling the relative lack of official control of foods' quality in Nepal – many products sold loose without labels, adulteration an active problem and storage frequently inadequate – they felt they were healthier in Norway because the food eaten there was less likely to be contaminated and hence make them ill, which had happened "often" in Nepal (ibid). Thus the usual food-labelling practices in Norway (including ingredients lists, batch numbers and expiry dates) as well as the perception of a generally stricter Norwegian "monitoring system" of foodstuffs led Malla to conclude that these particular women "believed that the clean, better quality of food and good sanitation condition [sic.] were responsible for their good health in Norway" (ibid: 75).

Although interpreting the question of health quite differently, both groups of Malla's interviewees appeared to rate the Norwegian diet as healthier than the Nepali one. And in both cases the notion of 'healthy' accorded with largely biomedical accounts – be it specifically in terms of nutrition, or related more directly to "bacteria and mould". Strikingly absent from Malla's work, however, was any mention of alternative, non-biomedical ways of evaluating food. Most obviously, there is no mention of the 'hot'/'cold' dichotomy, which as the next chapter shows (and Chapter 6 will also make clear) was evident, albeit inconsistently, in many of my conversations with Nepalis living in Norway. Its lack of presence in Malla's study is thus surprising. She recorded that her interviewees were all "highly educated females" (ibid: 84) and made some links between education-level and knowledge of nutrition. Yet as we have seen, most of the Nepalis I worked with were also highly educated – middle class, mostly from urban settings where biomedical norms are likely to have taken greater precedence (see Chapter 2) – and well-versed in 'nutritional' accounts of food (see Chapter 4). And yet, as the coming chapter makes plain, my respondents demonstrated an ability in their dietary habits and practices of operating both within and outside of the biomedical system; moreover, the vignette opening this thesis shows that biomedically-trained Nepali women can and do in certain of their dietary practices act according to non-biomedical logics.

Returning to Malla's findings, therefore, I think it possible (likely, even) that such exclusively biomedical evaluations of food *might* have been partly due to the women's education but potentially were also the response deemed most appropriate to a researcher interested in, and talking in terms of, nutritional science. In other words, conscious of their own perceived educational status as well as that the researcher, the women spoke about food in ways that they perceived Malla wanted to hear. Thus despite the Nepali-specific focus of her dissertation and

the potential this gave to considering additional, non-biomedical understandings of health and wellbeing, Malla essentially reproduces the biomedical model hegemonic within Norwegian public health research on South Asians. The extent to which this was due to her professional training, institutional allegiance and expectations associated with that, or her respondents' perceptions of themselves and their questioner, or a combination of all these factors can only remain open to conjecture, however.

'Socio-cultural perceptions and practices of dietary choices with focus on fat intake in middle-aged Pakistani women in Oslo – a qualitative study' (Dawes 2006)

Dawes (2006) focused on middle-aged Pakistani women living in Oslo and considered their perceptions and practices related to dietary fat intake. As with Malla's work, this was explicitly directed towards public health ends, in this case, "to identify possible barriers to changes in healthy choices of dietary fat intake" and thereby "discuss its implications in preventive healthcare" (Dawes 2006: 4). Compared with the relatively young, apparently healthy, male and female Nepalis that I interviewed, Dawes's study cohort differed markedly. The eleven Pakistani women and one Afghan woman she worked with, aged between 42 and 70 years of age, all had (bar the youngest) a diagnosis either of diabetes (eight), coronary heart disease (three) or both (two). Furthermore, all lived in multigenerational households (unlike any of the Nepalis I met) alongside their predominantly adult children and, in some cases, grandchildren. The women had been resident in Oslo for from nine to thirty years and most had a limited ability to read or speak Norwegian. Their schooling in their native country, with the exception of one woman who had a university degree from Pakistan, was quite variable and some of the women were not fully literate in their first language.

The considerable differences in characteristics between the Nepalis who I worked with and those in Dawes's study clearly limit the comparisons possible between the two studies. Nevertheless there are some useful intersections regarding eating practices in relation to health, notably an active consideration of foodstuffs' potential heating/cooling qualities and, in some cases, digestibility. A further similarity was that in both groups *ghee* was held to impart both nourishment and 'correct' taste to dishes. These commonalities are not unexpected given that Nepal, Pakistan and Afghanistan are near geographical and cultural neighbours, sharing similar staple foods and ingredients as well as an established presence of medical systems other than biomedicine (principally Ayurveda and Unani-Tibb, both of which are humoral and incorporate the hot/cold binary into their classification of foods).

Dawes's discussion of her interviewees' perceptions of dietary fat cohered most clearly around their views and uses of *ghee*. The women had been advised by biomedical personnel to reduce

their consumption of fats generally and saturated fats (something *ghee* – as a butter derivative – is classified as) in particular, due to their diagnosed diabetes and/or coronary heart disease (the one group member without either of these had a husband with both). Instead plant oils, notably olive oil, were advised as worthy alternatives. However, the women, Dawes explained, made their selection of culinary fats based largely on reasons other than the biomedical, drawing instead on humoral medicine, experience and taste preferences within their household. Some apparently made some efforts to follow the guidance, substituting with sunflower and corn oil which were cheap and widely available, yet several remarked that while they had heard the terms ‘saturated’ and ‘unsaturated’ before they “did not know its meaning” and hence it had “no importance to them” (Dawes 2006: 41). In contrast, the continued use of *ghee*, especially in preparing children’s food and dishes intended for guests or for festive occasions connoted the ingredient’s prominent meaning and importance to them as a an appropriately heating and nourishing foodstuff, which also enhanced food by giving it a particular flavour. According to Dawes *ghee*’s status was evident in that “even just a small dash was sufficient making it the ultimate symbol for expressing care and nourishment and good cooking skills, providing correct taste and flavour of [*sic.*] festive foods” (ibid: 67). Olive oil, although recommended in biomedical guidance they encountered, was rarely used as it was unsuitable for cooking at high temperatures (necessary in preparing curries as well as snacks), expensive in comparison with other vegetable oils and many of the women’s (adult) children “don’t like the taste” (ibid: 44). Moreover, in humoral terms, olive oil was considered to have problematically ‘heating’ properties “which could lead to itching or give rash or eczema” (ibid: 43). Dawes, in line with her public health aims, proceeded to frame the high volumes in which the plant oils were used by the women, as well as the methods of cooking (frying especially), as a “health hazard” and/or “risky” (ibid: 44, 53).

Notions of digestibility also informed Dawes’s respondents’ views on foods. In this case, dishes needed to be cooked for a long time, together with appropriate spices (the selection reflecting the cook’s experience and expertise), time and heat required to bring out the necessary digestible (and nourishing) properties as well as “taste and flavour” (ibid: 35). Cooking methods also influenced the digestibility and perceived nourishment of the food: frying, roasting and baking were considered to result in strong, nourishing foods that were also more digestible, while boiling and steaming (especially without spices or fat) were seen as foods suitable for “elders, sick and babies with weak digestion” (ibid). These positions were challenged by some of the women’s children who were apparently influenced “by interacting with the host [Norwegian] population” (ibid). Nevertheless, as principal preparers of the food within the household, the women expressed doubt about their offspring’s judgement in this case and usually continued with their preferred cooking methods.

In my view, Dawes's research offers a useful example of how alternative understandings of food, entirely logical and reasonable within their own paradigms, came up against the biomedical account, which was so dominant in the diaspora setting. In this case the biomedical category of fats (which presupposes simple substitutions are possible between like-structured members) was cross-cut by an alternative evaluation of some of those same members. *Ghee*, for example, was afforded significant qualities especially valuable to physical health and social wellbeing – the good taste it created crucial in preparing foods both for household members and guests. Olive oil (so 'good' according to biomedical metrics), meanwhile, was thought to give rise to skin problems. Similarly, notions of digestibility opened up space for different ways of linking cooking techniques, including seasoning, to the resulting food's nourishing capacities. In both instances, the contingency of biomedical nutrition-based readings of foodways was exposed. Moreover, recalling Pollan's (2008) illuminating account of biomedicine's contradictory accounts of dietary fats over recent decades, it underscores further how variable, and neither 'fixed' nor necessarily 'true', biomedical notions of food can be.

Dawes herself concluded that her interviewees "chose to fall back on their own perceptions regarding nourishment and digestibility more than biomedical nutritional facts" (ibid: 70). "Socio-cultural factors" including the women's understandings of "traditional medicine", she saw as the cause of this, yet also their being part of a "minority community" in which a woman's social capital and perceived competence rested on her ability to provide nourishing and flavoursome meals – both for the household and in the community more broadly, offering guests "lavish, tasty, rich, energy dense foods prepared generously with *ghee*, meat, salt, spices and sugar" (ibid 64, 70). Dawes's assertion, however, that "concerning fats, the message 'fat is harmful' as conveyed by the health professional is insufficient without understanding of the role of such foods in the lives of these particular women", provided a welcome acknowledgment of the breadth of influences informing her respondents' foodways (ibid: 5). This was so even if her ultimate recommendations – dietary messages (from the "health professional") taking in "cultural and ethnic differences" and tailored to "each specific ethnic group" (ibid) – sought to instrumentalise cultural understanding for the benefit of biomedicine, returning her firmly to a public health fold where narrow biomedical readings of nutrition prevailed.

It is worth noting that both Malla's and Dawes's work focused on women, presumably because they were generally responsible for the preparation of meals; an assumption evident within most of the public health literature reviewed in this chapter, in fact. Back in India (Donner 2008a; Staples 2014) and in Pakistan (Hofer 2016) however, men often did most of a household's food purchasing, and thus controlled to a large degree what was consumed. It might therefore be reasoned that if this remained the case in diaspora, 'educating' South Asian immigrant women

about ‘correct’ foodways could be an ineffective means of changing a household’s eating habits. However, without addressing the topic specifically, the inference in both Malla’s and Dawes’s studies was that women did much of the food shopping, something also found by Ray among Bengalis living in the US (2004). Moreover, as will be discussed in the coming chapter, food shopping for the Nepalis I spoke with was not consciously gendered in any particular direction. Taken together, these findings demonstrate a further assumption made about South Asians that is present in the extant Norwegian biomedical literature: the equating of food purchasing and preparation automatically with women. Accordingly, it also exposes how when these public health experts talk about ‘culture’ they often hold insufficiently nuanced views of what constitutes that ‘culture’, highlighting again their over-simplistic use of the term. It is worth adding that such uncomplicated evaluations of ‘culture’ and the associated assumptions communicated within Norwegian public health literature depict South Asians bodies and subjectivities – especially those of women – in a profoundly stereotypical way. And given the longstanding commitment to gender equality in Norway already discussed (see Chapter 2), is perhaps surprising; moreover, whether conscious or not, it could be interpreted as a means of ‘othering’ these South Asian immigrants.

More even-handed considerations of immigrant health issues in Norway?

The biomedical research on South Asian foodways in relation to health coming out of Norway that has so far been discussed presents a seemingly limited view both of South Asian immigrants as well as their cultural practices. However, at least two Norwegian-authored public health works appear to offer a more multifaceted approach to understanding immigrant dietary habits and practices, and hence the possibility of a more even-handed consideration of immigrant health issues there. The first was an article co-written by Norwegian public health researchers and an anthropologist (Fagerli et al. 2005); the second, in *Folkehelse i et migrasjonsperspektiv* (Nor: Population health in a migration perspective), a Norwegian textbook intended primarily as a teaching resource for health students and workers (Kumar & Viken 2010).

Fagerli et al.’s (2005) article focused on the perceptions of fifteen Pakistani-born adults, all with Type 2 diabetes and living in Oslo, regarding the dietary advice they had received there. Early on the work struck an (unusually) self-reflective note in acknowledging the Norwegian health system as “dominated by the majority [Norwegian] ethnic group, and where health-workers’ multicultural knowledge is often limited” (ibid: 296). And, through in-depth interviews, hearing of how the Pakistanis often experienced health personnel referring to “‘Pakistani food’ as ‘bad’” in relation to diabetes, the researchers drew some thoughtful conclusions (ibid: 299). Firstly, that such devaluation of Pakistani food-culture by Norwegian health sources conveyed the

message that the Pakistanis would need “to reject their own food culture” in order to deal successfully with their diabetes (ibid). Secondly, and accordingly, that such a negative equation would “hamper” any efforts towards better diabetes care (ibid).

More generally, the authors point up the “somewhat asymmetric meeting” between an ethnic minority patient and typically Norwegian health worker, where knowledge occurs at two different levels: one, the “universalising” biomedical position, which equates diabetes to blood sugar, assumed (by the health personnel) ““valid”” across cultures, and held by both health worker and patients, the latter to varying degrees; and two, the “culturally specific” knowledge, whereby health workers translate medical advice into practical guidance that draws upon their own “local cultural practices as a Norwegian” (ibid: 302). One result, for example, would be recommendation of bread-based meals to those for whom it could seem “irrelevant” (ibid). Although not on the scale of what Farmer (1999) has described in identifying forms of structural violence and inequality within biomedicine, Fagerli et al.’s (2005) attention to the asymmetry of the Norwegian health worker–ethnic minority patient encounter bears its echoes, by illuminating the everyday power dynamics at play within biomedical settings. It is worth adding that many health personnel working within the Norwegian hospitals and clinics are now of ethnic minority background, nurses and care assistants in particular, and the majority coming from lower-income nations.¹⁹ Furthermore, as already noted (and will be seen in coming chapters), several of my Nepali respondents were themselves employed in the health services, including three doctors (although only one saw patients regularly, of the other two, one worked mainly in a laboratory and the other was a university-based researcher). Thus the extent to which ethnic minority patients encounter ‘typically Norwegian health workers’ drawing upon ‘local cultural practices as a Norwegian’ may be diminishing. Nevertheless, I would argue that even in the absence of ethnic differences between patients and staff, the dominant position of biomedicine within Norway (and inherent sense of superiority to other understandings of health and wellbeing implicit within that), means that the power imbalance there in favour of biomedicine is likely to remain, at least within biomedical settings.

¹⁹ Figures from the most recent official analysis (SSB 2016b) show that 398,000 people with a health care education were employed in Norway’s health and social services at the end of 2015. Of these, about 37,200 were immigrants and non-residents. Nurses were the largest group (11,000 persons), while physicians were the second largest (5,200 persons) (ibid.), in both categories the figures up from the previous year. Among these immigrants, the largest proportion came from Asia, Africa, Latin America or Oceania (excluding Australia and New Zealand), totalling 15,967 of which 6,092 worked as auxiliary nurses, care workers or health workers, and 3,484 as nurses, midwives or public health nurses (ibid).

Overall, instead of focusing on the need to better ‘educate’ diabetic South Asian immigrants to Norway in the ways of biomedical health (as so much of the other public health literature already discussed appears to do), Fagerli et al. located lack of knowledge in Norwegian health workers: “health workers’ [sic] would benefit from taking the time to expand their knowledge of the many positive aspects of ethnic minorities food-culture in relevance to diabetes and apply this knowledge in their patient encounters” (ibid: 303). Thus the authors ended by asserting not only that possible advantages of “traditional-food habits” were insufficiently considered within existing Norwegian biomedical guidance on diabetes management, but also that health personnel’s inadequate understanding of their patients’ individual perspectives (“reached through dialogue”) risked making care for the disease “routinized and based on stereotypical assumptions about beliefs and practices of particular ethnic minorities” (ibid). This research still sought to advance the progress of biomedical care of South Asian immigrant patients in Norway. Nevertheless, in comparison with the other Norwegian-based public health research discussed, its arguments were balanced much more in favour of acknowledging the value of immigrant dietary knowledge and practices in and of themselves, and less in trying to bend or ‘crack’ it according to exclusively biomedical ends.

Kumar and Viken’s textbook (2010), *Folkehelse i et migrasjonsperspektiv*, meanwhile, took care early on to highlight the potentially problematic nature of the terms ‘ethnicity’ and ‘culture’.²⁰ Apart from a stated preference for the expression ‘*kulturell tilpassning*’ (Nor: cultural adaptation), the authors themselves offered no especially firm (re)definitions of either ‘ethnicity’ or ‘culture’. Nevertheless, their efforts to make health personnel aware of a need to weigh up the relative weaknesses and strengths of such concepts when utilising them is laudable, even if such understanding seemed rather absent in the examples of subsequent Norwegian public health literature discussed above.

²⁰ Ethnicity was acknowledged by the authors to encompass many aspects, including membership within a particular group of the human race, and/or assumed belonging on the basis of certain shared characteristics, kinship, geographical proximity, shared language and cultural tradition (Kumar & Viken 2010: 12 – 13, citing Bhopal 2004). It was also socially and culturally defined, they explained, thus did not denote objective cultural differences but rather related to the social communication of cultural difference (ibid – citing Norwegian anthropologist Hylland Eriksen, although no reference is actually given). In discussing the term ‘culture’, Kumar and Viken were careful to identify it as a “dynamic and constantly changing” phenomenon, and that cultural diversity involved interplay between more than simply two cultures (host and immigrant, for example) (ibid: 13). They also acknowledged the limitations yet ready appearance of the concept of ‘culture’ within the health field, the reader ultimately cautioned against using it in isolation.

The chapter, *Kosthold og helse* (Nor: Diet and health), written by Kumar and Ayub (2010), was especially relevant to this research. Underscoring the public health-related position and purpose of the overall publication, it drew regularly and readily on biomedical and public health research to support points made, with the Norwegian studies HUBRO, UNGHUBRO and OIHS featuring quite prominently. Also using Kocktürk-Runefor's (1991) model of foodways to explain the shift in eating patterns following migration (changes operating within the two poles of identity and taste – see Appendix D for further details), they acknowledged immigrants' dietary habits and practices as being shaped by numerous factors, nutritional concerns only one of them. Echoing some of my Nepali respondents' comments on what influenced their day-to-day eating (Chapter 4), the authors described “the struggle between tradition and knowledge on one side and costs, accessibility, time pressure and advertising on the other ” (ibid: 174).²¹ Furthermore, as will be seen, the views of the Nepalis I encountered were similarly reflected in Kumar and Ayub's observations on the transition in food habits following migration to Norway: fewer vegetables and lentils, and increased consumption of meat, dairy, processed grains, and oil; the relative affordability of animal products, compared with their homelands; and the higher price and poor selection and quality of fresh vegetables in Norway, especially in winter (ibid: 177 – 8).

That food is not simply a question of nutrition but important in “*sosialt liv og identitet*” (Nor: social life and identity) was clearly communicated, Kumar and Ayub highlighting the need to respect the meaning of foods and foodways in other cultures, especially the possible influence of religion (ibid: 180). At the same time, counselling against essentialising visions, they drew attention to the fact that people from the same cultural context can, nevertheless, follow traditional foodways differently. The authors went on to make some general (and potentially essentialising), public health evidence-based observations about the food choices of immigrants to Norway. The bullet points below summarise them, capturing the way in which the textbook made concerted efforts to engage more thoroughly with food-related immigrant health perspectives and experience, yet at the same time maintained an overarching public health and biomedical stance:

- Among Muslims, food choice can be limited in relation to bread toppings due to concerns about the contents (risk of animal-based substances within the ingredients, especially the e-numbers)
- Subjects of research studies often identified in themselves a lack of nutritional knowledge

²¹ From the Norwegian: “*det strid mellom tradisjon og kunnskap på den ene side og kostnader, tilgjengelighet, tidspress og reklame på den andre*” (Kumar & Ayub 2010: 174).

- The poorer socio-economic conditions of most immigrants compared to ethnic Norwegians (i.e. resulting in nutritionally undesirable foods being chosen, because they are cheap)
- The presence of different family structures within immigrant groups, the significance of the bigger family in how that affects both the choosing and preparing of food (including the role of elders in determining food-related decisions)
- The importance of food in hospitality
- Put most simply, a comparison of Norwegian vs. immigrant food choices can be described as: more ‘bread-meals’, less warm food vs. less ‘bread-meals’, more warm food (for example, warm food for breakfast and dinner)
- A preference for frying over baking
- Regarding meat: a taste preference among some for red meat (rather than white); also an expressed lack of knowledge about different types of meat, not least from those with little existing relation to fish as food (i.e. Pakistan, Somalia, parts of Middle East)
- Regarding pulses and lentils: a shift from pulses to meat, and whole grains to refined ones. Furthermore, an apparent non-awareness about the nutritional difference between the different forms of grain. (Adapted from Kumar & Ayub 2010: 181 – 82)

The latter part of the chapter concerned *kostholdveiledning* (Nor: nutritional guidance), and was effectively a series of ‘how to’ sections aimed at engaging immigrants more fully and successfully (from a public health and biomedical perspective) in practising ‘healthier’ foodways. The importance of listening to immigrants was underlined and linked to the (instrumental) point that “a well-informed and participative user is in a better position to achieve a good result in meeting with health and social services” (ibid: 183).²² The authors thus argued that one of the more significant reasons for previously poor results from official dietary information dissemination efforts, campaigns and services aimed at immigrants had been that they had not gone through “*riktige kanaler*” (Nor: the right channels) (ibid).

In keeping with the gendered trend and ‘culture’-related assumptions identified earlier, immigrant women were identified as one such ‘channel’, presented as key figures to reach in diet-related public health efforts because of their principal role in food-making (ibid: 183). Group-style activities, such as meetings and food-making courses were considered more effective than brochures (almost always direct translations of Norwegian-language versions), which many immigrants apparently saw as not really applying to them. While Kumar and Ayub

²² From the Norwegian: “*en velinformert og deltakende bruker har større forutsetninger for å oppnå et godt resultat i møte med helse- og sosial-tjenester*” (ibid: 183).

called for more appropriate written materials to be produced, the value of personal conversations was also underlined. This resonated with something Sanjay, one of my Nepali interviewees, told me about a visit he and his wife, Mangala, had made to the midwife: “they gave us some, you know, brochure, written in English and Norwegian too. And they said ‘read thoroughly’, ‘read it thoroughly’, but they don’t say [give spoken advice]. I think it is a good idea to say”.

Two things stood out from Kumar and Ayub’s final paragraphs. Firstly, the authors invoked the term ‘epidemic’ twice to describe the growing prevalence of diabetes and overweightness among immigrants. Their use of this strong rhetoric to underscore the perceived severity of the risks reasserted the public health-informed basis (and bias) of their work, which then went on to call for the development of strategies to avoid “a trend in which immigrant groups incur chronic diseases caused by unhealthy eating habits” (ibid: 187).²³ One such strategy was the need for “*ressurspersoner*” (Nor: resource people), which brought the second notable aspect of the conclusion: explicit reference to a need to decode immigrant cultural practices in relation to health. These ‘resource people’, coming from immigrant backgrounds and hence with language skills as well as contacts and confidence within a given group, are, according to Kumar and Ayub, the ones to more easily “*åpner dørene*” (Nor: open the doors) and “*knekke koden*” (Nor: crack the code), enabling communication of health information to immigrants. They could also be points of contact, for example during publicity campaigns, facilitating access to “*sentrale personer i innvandremiljøene*” (Nor: central people within the immigrant milieu) (ibid: 188).

Ostensibly, the chapter *Kosthold og helse* appeared to offer a plausible corrective towards overly simplistic views of immigrant health perceptions and foodways, Kumar and Ayub paying quite considerable lip service to the need to acknowledge immigrants’ own cultures and foodways. However, little in the way of practical examples of this were provided; in most instances studies from the public health domain were cited. A considerable emphasis was also placed on diabetes and weight-related issues and, although seldom explicit, the focus was on South Asian immigrants, specifically those from Pakistan. This was reflected in, or perhaps more a result of, most of the research referenced being based on work with this group (as already stated, one of the largest non-European immigrant groups resident in Norway). Furthermore, positing the idea that immigrant practices in relation to food and health represent ‘codes’ that in this case Norwegian health workers need ‘to crack’ I find curiously reductive. This is all the more so for coming from writers who have lived experience of coming from

²³ From the Norwegian: “*en utvikling der innvandrergrupper pådrar seg kroniske sykdommer som følge av usunne matvaner*” (ibid).

backgrounds with rich and diverse cultural practices, Indian in Kumar's case and Pakistani in Ayub's. In sum, I would suggest that their text added nuance to the strands of thought coming out of Norwegian public health services in relation to immigrant dietary habits and practices, while nevertheless remaining (intentionally) embedded in a biomedical nutrition-based account of foodways. Its purpose was as instrumental as many of the other biomedical works already discussed, aimed at better comprehending immigrant foodways, in order to influence them more effectively according to the logics of the state's dominant medical system and interests. Accordingly, Kumar and Ayub's work represents a further example in support of my second key argument concerning the dominance of biomedical models of nutrition within Norwegian public health research and resources.

During fieldwork I met with Kumar and we discussed the topic of immigrant foodways in more detail. An Indian-born woman, trained originally as a doctor in Bangalore, she married a Norwegian and has lived in Norway for over twenty years. During this time, she had held several public health-related positions within the Helsedirektorat, as well as collaborating with numerous international agencies, including UNICEF, the World Food Programme (WFP) and the World Bank. An experienced researcher, having undertaken public health-related investigations in the Middle East, Africa and China as well as in Norway, in addition she holds a PhD from the University of Oslo, her thesis title, 'Ethnic differences in obesity and related risk factors for cardiovascular disease' (2005). Kumar was also the main author of the OIHS (FHI 2008). At the time of our interview, she worked as the director of *Nasjonalehet for Kompetanse i Minoritetshelse*, NAKMI (Nor: National Centre for Minority Health), a government-funded body that "works to promote knowledge about healthcare for immigrants and their descendants in Norway" (NAKMI 2015).²⁴ She therefore continued to work very closely with state institutions such as the Helsedirektorat, for example taking a lead role in their seminar 'Diet and minorities', organised in 2011 (its findings and conclusions fairly consistent with the contents of Kumar and Ayub's chapter, discussed above). That a fair proportion of our conversation (carried out in English – Kumar is a very skilled linguist, fluent in several languages, not least English) went over similar ground to that covered in the 'Diet and health' chapter is unsurprising. However, she made some interesting additional points.

Kumar spoke of the "cognitive dissonance" she had encountered during her research with Pakistani immigrants in Oslo. This was, namely, that her respondents were eating differently (less rice, more wheat; less *ghee*, more vegetable oil) but when asked about it said they were

²⁴ From the Norwegian: "*arbeider for å fremme kunnskap om helse og omsorg for innvandrere og deres etterkommere i Norge*" (NAKMI 2015).

eating the same as they had in Pakistan. Aside from food diaries that could be useful but relied on people filling them out regularly and honestly, Kumar said the most effective way she had found to establish what people were really eating was to ask how they went about making and preparing food. She gave the example of *keema matar*, a meat and pea dish, recounting how through one interviewee's description she learned that the ratio of meat to vegetables had effectively inverted. Summarising her experience of that research, Kumar asserted that despite being ostensibly the same recipe, because in Norway meat was "cheaper" (than in their home country) and "high status", Pakistanis tended to use it in much greater quantity. At the same time, because vegetables were judged to be relatively expensive and of less good quality compared to what they were used to in Pakistan, these were used more sparingly.

"Food status is a useful way to think about food ways in relation to migration", Kumar told me, defining it as related to "cost, availability and position of the specific food within the overall diet". That within South Asian cultural practices, fruit usually has a higher status than vegetables – for example used as an offering to gods and to guests – was one particular distinction which she addressed. I had encountered this as a guest in the Nepali households I had visited during fieldwork. Either on arrival, or if the meeting took place between mealtimes, it was not unusual that I was offered a plate of cut fruit. Kumar's clarification, that because they occupy hierarchically distinct categories within South Asian beliefs and practices relating to food it "is unwise to combine fruit and veg [*sic.*] within a single category", was an additionally valid and valuable insight, given the overwhelming tendency to collapse both into the same category within biomedical and public health nutrition-based accounts and guidance. With regard to vegetables, she offered that in "low-income countries" they had a lower status, while in "richer, middle- or high-income countries" their status was higher. With pulses, lentils in particular, the case was less clear: they have a central role in the South Asian diet, yet their status within the diet among immigrants here in Norway was, she had found, "uncertain". And although "symbolically powerful", Kumar suggested that they might be dropped in favour of (the higher status) meat if and when opportunities allowed. Dairy foods, meanwhile, were generally perceived as high-status, "a higher fat content", she added, particularly valued among South Asians for whom it connotes "luxury" and "better taste".

Had Kumar, I asked, experienced people saying they understood what was being told to them about nutritional aspects of diet, but nevertheless disagreeing and declining to change – a reasoned resistance, in other words? "People reject, yes", she replied, "people choose not to compromise on certain food habits". By way of example she mentioned how efforts by health personnel to encourage South Asian immigrant women to switch over from full-fat milk to semi-skimmed or skimmed milk in their food and drink preparations, had been met with

opposition by the Pakistani women she had spoken with. They justified their position to her with regard to taste: food and drinks made with reduced fat versions of milk simply “do not taste so nice” was her recollection of what they said.

The additional information and experience Kumar shared with me was interesting, her own personal and professional background adding further depth to her knowledge. Nevertheless, the views she presented remained anchored, fundamentally, to a public health position, and alternative, non-biomedical accounts of health – such as the humoral hot/cold dichotomy – even if they were acknowledged were not obviously afforded any validity. Consequently, as with her co-authored text book and chapter, Kumar’s views while at first sight suggestive of a more even-handed consideration of immigrant foodways, in the end repeated and endorsed the biomedical accounts of other Norway-based public health researchers. Comparing her findings with mine, moreover, I believe I experienced rather less “cognitive dissonance” in conversations with Nepalis about their foodways. As the coming chapter will relate, most seemed quite conscious of and able to describe how their dietary habits and practices had altered since coming to Norway. Furthermore, regarding “food status”, the majority reported similar shifts in meat and vegetable consumption, usually explained in terms of cost and taste, but in almost every case the milk I was offered was *lett* (Nor: semi-skimmed), and everyone I asked was aware that the different types of milk had varying fat content. Based on my own experiences, I have no doubt that both the taste of their food and the honourable treatment of guests remained very important to those Nepalis, yet their expression of this through certain foodways is less clear-cut than Kumar’s interpretations suggested. One possible reason for this could have been my explicitly identifying myself to the Nepalis as an anthropological researcher, interested simply in what they did and thought about that, and not as someone intending to change their eating habits or practices in any way.

Conclusion

This chapter has offered a critical reading of the way that foodways of South Asian immigrants to Norway are portrayed within the Norwegian public health sphere. Given the absence to my knowledge of any equivalent anthropological research on this topic, the findings here provide an important context against which to read and compare my own ethnographic work on the foodways and health-related perceptions of Nepalis living in and around Oslo, the substance of the coming chapter. All of the studies and works described and analysed above acknowledge the value of a more rounded understanding of others’ eating habits and practices. Yet, accepting the professional and institutional contexts of the researchers and the research, nearly every Norwegian public health publication reviewed nonetheless demonstrated an overall distinctly

reductive envisioning of the dietary habits and practices of the South Asian immigrant groups they considered.

My examination of the public health studies focused on the dietary habits of South Asian immigrants living in Oslo has shown that while cultural information is sought, it has been largely for very singular ends. 'Culture' is often presented in a overly-simplistic way, and as an unwieldy variable (or code) that needs demystification and/or to be made more legible (and hence amenable) to Norwegian public health and biomedical service requirements. Once reinterpreted in terms of nutrition, it can be directly (preferably quantifiably) related to the current, local biomedical understanding of health, and to particular states of 'un-health', namely obesity, cardiovascular disease and diabetes. Moreover, this cultural knowledge, now newly reconfigured, is then ready to be disseminated back into the relevant groups, preferably via the 'right channels'.

Malla (2005) and Dawes (2006) presented and discussed their informants' sometimes alternative appreciations and understandings of food with regard to taste, social relations and, in Dawes's case, the humoral medicine-inspired accounts of the hot/cold dichotomy. Nevertheless, both researchers' own interpretations were ultimately related to concepts of (biomedical) nutrition, and their subjects' health judged in those terms. They therefore reiterated the message conveyed by the medical and public health studies. Kumar and Viken's textbook (2010), the chapter by Kumar and Ayub within it as well as my conversation with Kumar, expanded the basis from which understanding might be gained but were ultimately as geared towards biomedical reasoning and the realisation of public health interests as the other works. Fagerli et al.'s (2005) article stands as an exception among all this work, in its appreciation of immigrant knowledge and values, yet seems to have had little subsequent influence if the later public health research reviewed here is anything to go by.

That Dawes, Malla, Ayub and Kumar are themselves immigrants is interesting and notable: their experiences might well have furnished them with prior knowledge of the foodways they were investigating, and their ethnic status allowed more straightforward access to informants. It should not, however, be overemphasised, not least because to do so would be to prioritise one aspect of their identity over others. As scholars highly educated in public health or related subjects, the authors identified themselves not only as Indian, Nepali or Pakistani but as health professionals working within a particular health paradigm. This also serves as a useful reminder not to perceive one's own respondents' attitudes towards food only in relation to a reductive understanding of 'culture' (especially given the evident tendency identified here within Norwegian public health research to engage in such narrowing endeavours). Moreover, looking

back to Chapter 2, to the middleclassness of the Nepalis I worked with, we see that class too – and quite apart from ‘culture’ – can be a factor potentially influencing dietary habits and practices.

Returning to the main arguments advanced in this thesis, it is now clear that biomedicine occupies a hegemonic position with Norwegian public health interpretations of South Asian immigrant foodways – my second key argument. The research and resources already described evince a distinctly instrumentalist approach, while the evident perception of culture as a code to be cracked speaks to a hierarchy of values in which the dominant Norwegian cultural practices that privilege biomedical accounts of nutrition outrank any alternatives held by immigrants to Norway. In addition, I have drawn attention to the fact that most of the Norwegian public health research (which also informs resources such as Kumar and Viken’s textbook) on South Asian immigrants to Norway is based on Pakistanis, yet the conclusions are then used in a more general (and generalising) way to speak to concerns about the health of South Asians living there. However, differences between these Pakistani study subjects and the Nepalis I worked with, which are already suggested here, and will become even clearer in the coming chapter, make plain the inaccuracy of such an approach. And in so doing, it further justifies my first key argument: the need for disaggregation of the category of ‘South Asian’ within public research as well as the policies and resources that it informs.

This chapter also acts to signal the direction of this thesis. Through its critical analysis of existing Norwegian public health views regarding South Asian immigrant health it has not only provided a background context against which my own research can be read, but also laid out the problematic nature of the ideas of ‘culture’ and the instrumentalist approach currently operant within the Norwegian public health milieu. In the coming chapter, through my ethnography, I will show what a more nuanced view of foodways and related notions of health and wellbeing beyond a biomedical lens can throw up. This will, in turn, lay the ground for the two subsequent chapters, which focus specifically on ante- and postnatal foodways.

Chapter 4 – More than Nutrition: Foodways in Relation to Health among Nepalis living in Oslo and Ås

This chapter analyses the post-immigration foodways of the Nepalis I worked with in Ås and Oslo, and shows a group of people who readily applied biomedical nutrition-based ideas to their considerations of wellbeing. At the same time, many also drew on additional, non-biomedical evaluations of health, including ideas about foodstuffs' heating or cooling qualities, digestibility, taste and satisfaction, when making such assessments. And it is precisely this combined approach of my respondents that serves as a key framing point for this chapter, and argument of this dissertation as a whole: that in contrast to the prevailing dominance of biomedical models of nutrition in relation to health in Norway – so evident in the public health discourse surrounding South Asian immigrant, discussed in the previous chapter – there is a very real need to recognise how Nepalis (as well as other people in general) move between these and other, non-biomedical frameworks and evaluations of food-related wellbeing.

Conscious of the tendency in the existing public health literature to operate ultimately within definitively biomedical terms, I have tried to go beyond this limited perception to explore the ways in which the Nepalis I encountered during fieldwork related their eating habits and practices to feeling healthy or well. Therefore, while the words 'health' and 'healthy' inevitably came up in our conversations, I also used the terms 'well' and 'wellbeing' where possible. This was an attempt to expand the basis from which those I talked with could answer, and not least to try to reduce the frequent elision of health with its biomedical definition.

Although there are notable similarities between the foodways-related changes of Nepalis and other South Asian immigrants to Norway, there are also several discernible differences. Accordingly, speaking to another of this thesis's key arguments, my findings point again to the value of disaggregating categories such as 'South Asian', which, as already shown in Chapters 2 and 3, although convenient and currently in wide use within public health research, acts to efface important differences between those who fall within it. They also offer a reminder of how reductive the nutrition-based view of foodways, so dominant in so-called developed nations, can be; that cultural practices relating food and eating to wellbeing can and do incorporate – piecemeal or otherwise – numerous meanings and understandings, potentially encompassing but also reaching beyond the purely individual and biomedical. This is especially evident in the postnatal care practices of several of the Nepalis I worked with (see Chapter 6). There, as will be seen, a sense of collective responsibility for the new mother as well as recourse to Ayurvedic-inspired means of ensuring her wellbeing was evident. However, returning here to my Nepali respondents' more general perceptions in relation to health and wellbeing, to explore

them more effectively, some understanding of the basic changes to eating habits and practices they have experienced since coming to Norway is necessary.

Shifts in eating patterns and content of meals

The Nepalis I encountered described general shifts in eating patterns and content of meals very comparable to Malla’s (2005) findings and also, in some cases, to those described by Kumar and Ayub (2010) in relation to Pakistani immigrants to Norway. Several of my respondents explained the ‘usual’ Nepali meal pattern and timings in order to then contrast it with what they did now they lived in Norway. Below is a table, distilling their accounts to illustrate the two, differing practices:

IN NEPAL	IN NORWAY
7 – 8am Breakfast	6.30 – 8am Breakfast
Tea (often sweetened, with or without milk), biscuits	Bread, <i>pålegg</i> (Nor: sandwich fillings – usually cheese, processed meat, and/or sandwich pastes of cheese, meat or fish) milk/fruit juice, or breakfast cereal and yoghurt
9 – 11am Lunch	11.30 – 12.30 Lunch
<i>Dal bhat tarkari</i> (lentil soup, <i>dal</i> , with boiled rice, <i>bhat</i> (boiled rice), and cooked vegetable and/or meat side dishes, <i>tarkari</i>) and <i>achaar</i> (pickles)	Slices of bread with <i>pålegg</i> plus fruit, or salad and fruit
3 – 4 pm <i>Khajaa</i> (snacks)	
Tea taken together with some warm food, encompassing a wide variety of things that could include fried <i>chura</i> (beaten rice), <i>momos</i> (dumplings), <i>pakauda</i> (deep fried wheat flour and vegetable snack), <i>samosas</i> , <i>roti</i> (warm flatbread), fried rice with vegetables	5 – 8pm Dinner*
7 – 9pm Dinner	Warm meal, which could be Nepali style (for example <i>dal bhat tarkari</i>), or something else (pasta, pizza etc.)
<i>Dal bhat tarkari</i> and <i>achaar</i>	8 – 9pm <i>Kveldsmat</i> (Nor: Evening snack)
	Slice of bread with <i>pålegg</i> ; yoghurt; ice-cream

Fig. 3. Table comparing typical Nepali and Norwegian daily meal patterns

*By Norwegian standards, where the working day usually ends at 4pm and school days earlier than that, around 5pm is considered a normal time for the whole family’s evening meal. Therefore, because most members were hungry and so as to eat together as a family, those Nepali families with children either ate around this slightly earlier time, or else fed the children before, the adults then eating slightly later in the evening.

While many said that the changes to their diets had been hard at first, most had adapted relatively easily as the time passed. Here are a few comments, taken from the conversations I had with Nepalis during fieldwork, which illustrate some of these usual shifts:

“Because of the work and study, we change our food habit from, actually only from the lunchtime, mainly. But in the evening time we make Nepalese food... because we don’t need Nepalese food two times [in the day]”(Anil)

“Now we don’t prefer eating rice in the daytime, you feel sleepy, you know?” (Jyoti)

“Bread, that is a big change from there [Nepal] to here [Norway]. Now we eat it every day”, (Annie)

“I used to have rice every day in Nepal, but here in Norway one time a week” (Devi)

“Now I like *not* having rice every day – I like the variation” (Lalita)

“Because we have a variety of vegetables down there [in Nepal]. So it’s not every day that people prefer to have meat. Sometimes it’s also nice to have a vegetarian meal. But here [Norway] we have meat almost every day” (Nirmala)

“We don’t eat lots of meat but we do eat more meat than in Nepal because we eat it every day” (Mira)

“In Norway, it’s, actually whether I eat vegetables or meat, it’s the same price” (Anil)

“Living in Norway is a bit different office hours here; we don’t take *dal bhat* [lentil soup and boiled rice] in the morning here. So that has changed... I also take more fruit, more fruit I think. Uh, and also some of these things like milk products. I was not taking any cheese or anything in Nepal on a regular basis, but I take now” (Ashok)

What seemed more difficult than changes to the meal pattern or constituents was the temperature of the meals. Mira, who had lived in Oslo for more than ten years, still avoided salads and ate little bread, preferring to warm it in the microwave when she did; “if it is possible to eat warm food, then I choose that”, she said. Shanti, who came eight years ago to Norway after marrying her Nepali husband (himself resident there from his student days) also told me: “In the beginning it was more difficult to adjust to the cold food here in Norway than meal number”. Several others reported heating the bread too (often in a pan), or, as in Sunil’s case, rather than bread preferring “noodles, freshly warmed”, pasta, or reheated leftovers.

Time-pressures and time-saving techniques

The vast majority of Nepalis I spoke with told me that life in Norway required them to alter how and when they used their time in preparing food and meals. “Time” was, in fact, cited by nearly all my respondents as the principal factor limiting the possibility of making Nepali-style food as often as they had in Nepal, something Ray (2004) also encountered during his work with

Bengalis living in the US. As detailed in Chapter 2, nearly all the women and men I met with were either students or had jobs and found the working hours in Norway (usually 8am – 4pm) completely incompatible with the preparation and consumption of Nepali-style meals in the morning. The evening, however – and this finding is in common with what Malla's (2005) respondents told her – presented a chance to make and eat Nepali food, although time was still a constraint then for some. Shanti, for example, married, working full-time and with a son aged seven, said: "I try to cook Nepali style everyday but this is not possible", estimating that it took longer to prepare than "Norwegian-style food [that] can just be put in the oven". Nevertheless, she tried to circumvent this to some degree: "I try to modify", she said, adding seasoning to make it more similar to Nepali foods. This was quite a common strategy, I learned. Devi told me that when he cooked for his (Norwegian) wife and their daughter, "we make Nepali food but it is not typical. If I make pasta, I make the sauce Nepali style, using garlic and *masala* [a mixture of ground spices]". Spicy sauces to accompany pasta were, in fact, a particularly popular means of 'modification'. This improvisation, combining within their meals pre-existing knowledge and preferences with the current situation and all that that offered, is another example of the Nepalis as 'bricoleur' (Lévi-Strauss 1972). As already mentioned in Chapter 1, just as diaspora groups foodways are neither definitively 'traditional' nor modern, here again the food modification practices of my respondents (conceptualised as 'bricolage') provides a useful means of cutting through any assumptions that Nepalis chose *either* a Nepali meal *or* a Norwegian one.

Several of my interviewees also made use of their fridges and deep freezers to help maintain a more Nepali-style diet. Sunil, a post-graduate student in shared accommodation, would make a large quantity of *dal* and *tarkari* on one evening, store it in the fridge, then take from it over the coming days, reheating it either for his lunch or evening meal. Only rice did he cook freshly each day. Mira took the process to an even more advanced level. Clear that "one time a day we [she, her husband and her son] must eat Nepali food" but that she "didn't have the time or the energy after finishing work", Mira put aside a chunk of each weekend to prepare "proper Nepali food – *dal*, a little meat, and *tarkari*", enough to last for the entire week's evening meals. These she then divided up into portions and either refrigerated or froze them; like Sunil, she only made the rice fresh each day. Others I met with spoke of how deep freezers also allowed them to store other foods such as *sutki masala* (a sweet made most particularly for new mothers – see Chapter 6) and meat more easily, including goat, which was common (and much enjoyed) in Nepal but with very limited sources in Oslo. Prithi, meanwhile, told me that she sometimes cooked "deep frozen vegetables" at breakfast, since her husband at times liked something savoury to eat in the morning.

This ready recourse to using deep-freezers among the Nepalis I met stands in contrast to recent observations of Pakistani foodways in Oslo, where deep freezing was apparently new to many respondents and not favoured by them (Kumar & Ayub 2010). It serves, therefore, as just one example of how aspects of foodways between certain South Asian groups can vary. More broadly, it also suggests how access to technology can shape foodways. This can be the case both in diaspora but also in the native country. In India, for example, the more widespread and consistent supply of electricity (via generators) means that ice cream is now readily available even in some small South Indian towns where before there was no way of keeping it (Staples 2014). Caplan (2002), moreover, has described how certain time- and labour-saving measures have been enthusiastically embraced by Chennai's middle-class households, with processed foods for example (albeit only in limited amounts) regarded not only as "more 'modern'" and hygienic than pre-existing options, but also more time efficient as domestic servants had become increasingly expensive to employ (2002: 54). Donner, however, working with middle-class families in Kolkata, found that such "shortcuts" (as they were referred to by her informants) were often frowned upon, the women – who had usually given up work despite being highly-educated, to focus on their children's upbringing and education – using such "extensive food preparation" as a mark of their (socially-endorsed) self-sacrificing commitment to motherhood through the high quality of meals produced within the household, which in turn could be used to index and demarcate their membership within middle-class society (Donner 2011a: 58 – 59). While I have no doubt that the Nepali parents I got to know were equally devoted to their offspring, such culture-, gender- and class-based valencies seemed less overt in their lives, ready recourse to blenders, frozen and other pre-prepared ingredients more common and seemingly appreciated. That said, there is some scope for applying a class-based interpretation: comparing my and Donner's research, as Chapter 2 relates, it seemed that my Nepali respondents were engaged in becoming middle class in Norway, and therefore acted in particular ways (including using food techniques) that connoted this, while Donner's Kolkata mothers were doing so within Bengali cultural frameworks. In contrast, in not favouring certain food practices (deep-freezing, for example), the Pakistani immigrants to Norway appeared less inclined than my Nepali respondents to actively 'fit in' to such usual Norwegian middle-class behaviour, speaking further to the possible class differences between South Asian groups there (see also Chapter 2).

Ingredients: sourcing and costs

Aside from technological 'fixes', compared with ten years ago there is now much greater availability in Norway of ingredients needed to make Nepali meals. This appears not to have been the case previously, at least when Malla (2005) was conducting her research. In and around Oslo, and also in the other major Norwegian cities, there are now numerous so-called

innvandrere butikker (Nor: immigrant shops), usually run by Pakistani, Sri Lankan, Vietnamese or Turkish immigrants. Regular supermarkets in Norway have a relatively restricted and largely European-style repertoire of foods on offer and where ingredients representing other culinary styles are included (Mexican, Thai, Japanese and Italian the most common), the range is usually small and expensive. The ‘Immigrant shops’, meanwhile, sell foodstuffs found in the supermarkets but also those associated with South Asian, Middle- and Far-Eastern cuisines, as well as (reflecting trends in immigration) increasing quantities of ingredients integral to African and Eastern European meals. The prices for these additional foodstuffs, including a wide range of fruit and vegetables usually sold loose, are often cheaper than in the supermarkets, especially if bought in larger amounts.

As already stated, all my interviewees lived either in Oslo or in the nearby town of Ås. They were clear that it was easy for them to access the *innvandrere butikker*, there finding what they needed to make Nepali food as and when they wished. The response from Ram and Prithi, both living in Oslo, was typical: “availability, access-wise, you have most of the Nepalese food, most of the Nepalese food you would want to make. Here in Oslo it’s no problem”. “In the Pakistani shopping centre [in the neighbouring suburb] we can find everything there”, was the view of Mira, who lived in one of the city’s outer suburbs. Jyoti and husband, Anil, living with their sons in Ås, said much the same: “Yah, it’s no problem. That is because we have many Indian grocery [shops] in Oslo... And most of the things we can buy in ‘Rema’ [a Norwegian supermarket] also. We can get everything here [in Ås], only for some, some spices, for the spices we have to go to the Oslo Indian shops”. Sanjay (their neighbour, whom I had interviewed another time) concurred: “Near to Oslo people are not missing ingredients from Nepal. They all are available easily, in the Pakistani and Sri Lankan shops”. The students I met living in Ås in fact ‘clubbed together’, sometimes with Bangladeshi, Pakistani and Indian friends and neighbours, buying in bulk and then sharing out purchases. In one case they arranged a truck to deliver sacks of rice from Oslo, and more usually a group shared the car journey to Oslo, where they could stock up most cheaply buying large quantities of various oft-required ingredients, such as spices, *ghee* and vegetable oil, as well as find more hard-to-come-by products like goat meat.

In contrast, all of Malla’s interviewees “lived quite far from town” and did not seem to have ready access to transport hence “were forced to buy food in the nearby grocery stores” (2005: 62). She does not specify if these were supermarkets, only that they were more expensive than the shops in the town. Her interviewees described making several substitutions in their meals, related to both availability and price. Reflecting observations made by other researchers on South Asian immigrant foodways in Norway (Kumar & Ayub 2010), meat (relatively cheap in

Norway) replaced the vegetables (unavailable or relatively more expensive) that the women would have otherwise, preferentially have used. Almost all my respondents also acknowledged this relative inversion of prices and availability in Norway compared to Nepal, and that they ate more meat as a consequence. However, with the exception of a few, very specific sorts of green leafy vegetables, all said that they could easily get hold of the ingredients they wanted now they lived in Norway. Certain other specifically Nepali ingredients, notably the dried vegetable *gundruk*, dried meats and in some cases dried cheese as well as tea, my respondents either brought back with them when they travelled to Nepal, or got visiting family and friends to bring with them.

The greater range of ingredients stocked by the *innvandrere butikker*, much of it imported either from the UK but some from the countries of origin, meant that many foods familiar to Nepalis (and other immigrants) were not only present but also easily legible – both visually but also in terms of labelling/packaging. This made it relatively straightforward for them to select foods even if they understood little or even no Norwegian. I met several Nepalis who spoke no Norwegian and two who spoke no English. Even so, they described little difficulty in purchasing the foods they needed. Malla's interviewees, on the other hand, most of whom "did not understand Norwegian very well" reported difficulties reading the labels of foods in the shops they frequented, hence found the buying and preparation of "new food ingredients" especially problematic (2005: 66). All her respondents were Hindus, so a particular concern was to avoid eating beef, their uncertainty therefore particularly acute when trying to buy meat and meat-containing products. Yet some also worried that beef might feature in other less obvious foods, for example pizza, so avoided those too. To get around this, several of her interviewees (all women) went shopping with people more confident in the Norwegian language, either their husbands or friends.

While most of the Nepalis I spoke with were also Hindu, and some described checking ingredients lists to be sure beef was not present in whatever they bought, none expressed this worry about accidentally eating it. I think the reasons for this are two-fold. Firstly, those who did the food shopping (mostly women but, in the very few cases where the women spoke no Norwegian or English, men) knew enough Norwegian or English – which is widely and near-fluently spoken by almost all Norwegians – to read or ask about the ingredients of a given product. Secondly, and potentially more significant, was that the large number of *innvandrere butikker*, and in Oslo, several Halal butcher shops, made it possible for immigrants to avoid having to engage with supermarkets and their labels if they did not want to. Furthermore, both in *innvandrere butikker* and butchers' shops (also usually run by and employing immigrants), a fair chance existed that in addition to English someone there would speak a language similar

enough to an immigrant customer's own (for example, Hindi, which is from the same Indo-Aryan language family as Nepali and thus comprehensible to Nepalis), so it would be easier to confirm the origin of a given meat.

The Nepalis featured in Malla's research (2005) also cited the issue of cost as a reason for changing their food shopping habits and the meals they subsequently prepared. To my surprise many of the Nepalis I spoke with, while acknowledging Norway to be an especially expensive country to live in, said they thought that the relative price of foods was not much higher than in Nepal and, with regard to meat, markedly lower. Annie went so far as to say that when comparing relative incomes in the two countries she found that "Norwegian food prices are actually cheaper than Nepali ones". Those interviewees most conscious of the costs were either in part-time work or self-funded students; for those employed full-time or on scholarships, the price of food in Norway did not seem to worry them excessively. So while nearly everyone I spoke with mentioned price as a significant factor in their shopping habits, most also balanced it with quality, some citing health reasons for this. Mira, for instance, made an explicit link between good quality food and better health. She would not buy something "because it is cheap", the "cheap meat" on sale, for instance, "with lots of bones and fat". Others said much the same thing, often also citing meat as an example. Once again, we see how the Nepalis I worked with were, by virtue of their socio-economic position – a credible indication of their middleclassness – nearly all financially well-placed enough to eat 'well' within Norway, and able to choose ingredients based on factors other than price.

The influence of offspring and of husbands

Children were an important factor in determining certain changes to the diets of several of the Nepalis I got to know, something that has been identified more broadly among immigrant groups to Norway (Kumar & Ayub 2010). The majority of my interviewees were parents, many with children born in Norway, now in their early teens or younger. And, as I learned, their dietary preferences could exert an influence on the household's food-buying habits as well as, to some degree, what was eaten. Nayan and Maya's sons were apparently not fond of Nepali food. The elder boy did not even like rice, something he demonstrated during our meal together, eating only a small amount of the (very mild) chicken curry that was also on offer, before returning to watch television. "They are offered Nepali food", Nayan explained, "but they don't like that I think... Now they are more used to Norwegian food. Norwegian meals are what they got in the *barnehage* [Nor: kindergarten], possibly... they like salami and *pølse* [Nor: sausages]". Later on, opening the door of his fridge to show me the usual contents of his sons' sandwiches, I saw for myself the numerous packets of typical Norwegian foods, such as *servelat* (Nor: luncheon meat), salami and mild, yellow cheese as well as *lett melk* (Nor: semi-skimmed

milk), that were lying in there. Lalita's children, a boy of three and girl of six, "both like rice and *dal bhat*", she told me "but not *tarkari*", so she made "the spicy things not so much any more", and the family ate a Nepali-style evening meal three times-a-week "maximum". Even Mira, whose seven-year old boy "loves Nepali food", objected (along with his Nepali father) to having it more than once in a day. So although Mira, for herself, would have preferred to eat Nepali meals twice a day, they usually compromised for one of the meals, having "pizza, *pølse*, spring rolls or *momos*" instead, although the *momos* not often, she added, as she really did not like them.

In Norway it is usual that children from as young as one year old attend *barnehage* for the duration of the working day, Mondays to Fridays. There are generous state subsidies for families to support this, which enable both parents to work while at the same time their offspring are taken care of and provided with a stimulating and social environment (Helsedirektorat 2007). And while the children usually take a *matpakke* (Nor: packed lunch) from home, they are also provided with snacks and meals at the kindergarten. The state issues guidance regarding the nutritional content of these snacks and meals, for example advising that skimmed or semi-skimmed milk (rather than full-fat milk) is used, as well emphasising the consumption of fresh fruit and vegetables (ibid: 9-10).²⁵

²⁵ A brief summary of the Helsedirektorat guidance for Norwegian kindergartens regarding mealtimes and the food and drink served there is given:

"MEALTIMES – Kindergartens should: 1. Facilitate a minimum of two regular, nutritionally full value meals each day with brought along or served food 2. Set aside time at each meal, at least 30 minutes to eat, so children consume sufficient food 3. Facilitate being able to eat breakfast for the children who have not eaten breakfast at home 4. Have a maximum of 3 hours between each meal. Some children, especially the youngest, may need to eat more often 5. Facilitate the adults taking an active part in the meal and eating with the children 6. Facilitate a well-functioning and pleasant eating environment 7. Ensure good hygiene before and during meals and during storage and preparation of food 8. Attend to meals' educational function

FOOD AND DRINK: 9. The food should be varied over time and provide diverse taste experiences

10. Meals should be composed of foods from the following three groups:

Group 1: Wholegrain bread, wholegrain products, potatoes, rice, pasta etc.

Group 2: Vegetables and fruits / berries

Group 3: Fish, seafood, meat, cheese, eggs, peas, beans, lentils etc.

11. Plant Margarine and oil are preferred to butter and to butter-mixed margarine types

12. Drinks at meals should be skimmed milk, extra semi-skimmed milk or semi-skimmed milk

13. Water is a thirst quencher between meals, and should also be provided with meals

14. Food and drink with lots of added sugars should be avoided

15. Most commemorations and celebration should be conducted without serving of sweet and fatty

The food offered – bread, milk, cheese, sandwich fillings (*pålegg*), fresh fruit and vegetables – represents typically Norwegian fare. Children attending *barnehage* in Norway therefore become swiftly (and intentionally) socialised into Norwegian food habits and practices.²⁶ If their home diet is quite different this may take a little time but it usually happens. Maya, for example, recalled of her sons: “When they began, they started with *barnehage*, they didn’t like bread. Both children, because we don’t eat it often at home. So it was difficult to start with them. But after a few days they got used to it”. Consequently, increasingly used to local foods and foodways, these children brought their preferences home with them, and this was a common phenomenon among the other Nepali parents I talked with. Malla’s (2005) thesis, in contrast, makes no mention of children having this effect on her respondents’ diets. In fact it is not recorded if any of her interviewees actually had children. Citing Dewey et al. (1984), she speaks generally about the potential of children – because of their exposure to the dominant culture’s school system and media as well as usually being bilingual – to act as ‘cultural brokers’ in

food and sweet drinks” (Helsedirektorat 2007: 6)

Translated from the Norwegian: “*MÅLTIDER Barnehagen bør: 1. Legge til rette for minimum to faste, ernæringsmessig fullverdige måltider hver dag med medbrakt eller servert mat 2. Sette av god tid til hvert måltid, minimum 30 minutter til å spise, slik at barna får i seg tilstrekkelig med mat 3. Legge til rette for å kunne spise frokost for de barna som ikke har spist frokost hjemme 4. Ha maksimum 3 timer mellom hvert måltid. Noen barn, særlig de yngste, kan ha behov for å spise oftere 5. Legge til rette for at de voksne tar aktivt del i måltidet og spiser sammen med barna 6. Legge til rette for et godt fungerende og trivelig spisemiljø*

7. Sørge for god hygiene før og under måltidene og ved oppbevaring og tilberedning av mat

8. Ivareta måltidenes pedagogiske funksjon

MAT OG DRIKKE: 9. Maten bør varieres over tid og gi varierte smaksopplevelser

10. Måltidene bør settes sammen av mat fra følgende tre grupper:

Gruppe 1: Grovt brød, grove kornprodukter, poteter, ris, pasta etc.

Gruppe 2: Grønnsaker og frukt/bær

Gruppe 3: Fisk, annen sjømat, kjøtt, ost, egg, erter, bønner, linser etc.

11. Plantemargarin og olje bør velges framfor smør og smørblandede margarintyper

12. Drikke til måltidene bør være skummet melk, ekstra lettmeik eller lettmeik

13. Vann er tørstedrikk mellom måltidene, og bør også tilbys til måltidene

14. Mat og drikke med mye tilsatt sukker bør unngås

15. De fleste markeringer og feiringer bør gjennomføres uten servering av søt og fett mat og søt drikke” (Helsedirektorat 2007: 6)

²⁶ Referring to the guidance given in the preceding footnote, point 8. “Attend to meals’ educational function”, makes clear the pedagogical element of the meals, while the foods described in point 10. draw on the standard constituents of a Norwegian-style diet.

diaspora situations, promoting dietary acculturation. This they achieve, in part, by accompanying their parents' on shopping trips where they can assist with language-related issues but also request that certain foods are bought. Nevertheless, there is no evidence that her respondents experienced this.

The notion of children as 'cultural brokers' remains a useful concept within analysis of changing foodways – whether in diaspora or due to increased 'globalisation' more generally. Among Bengali immigrants to the US, Ray found that children raised there frequently preferred "pasta and hamburger sandwiches to rice and fish", and that second generation members were "typically equivocal" about bread, pasta and rice (2004: 53). Thus traditionally non-Indian items featured regularly within household meals even if not all members consumed them (ibid). Meanwhile, in India, both Donner (2008a, 2011) and Caplan (2002, 2008) have shown how children influenced the food provided within the home. In Kolkata, Donner (2011) found that with greater availability of 'foreign' foods, often heavily advertised, came an increasing demand made of mothers by their children (as well as sometimes husbands) that these were provided at home; that the women succumbed to such demands was in part to indulge their offspring or spouse yet also evidence, as discussed in Chapter 2, of the family's position as successful middle-class consumers. There was a gendered dimension as well, in that male family members might request and receive 'non-veg' items, whereas the women themselves remained vegetarian and discouraged such meat eating in any daughters (2008a, 2011). Caplan (2002), working in Chennai, noted that children's tastes influenced what foodstuffs were bought, for example pizza; moreover, youngsters were usually given more "leeway" with regard to observing household food norms, vegetarianism for example (2008: 139). These were often justified on nutritional grounds (for example, eggs allowed because they were regarded as a good source of protein), yet the gendered aspect was again present, men more likely to eat 'non-veg' food, at least outside of the home (ibid: 128).

Husbands, rather than children, were a principal influence dictating the meal content of Malla's (2005) Nepali interviewees in Norway. The women apparently gave "first priority to their husbands' choice as they are the most respected person in the family", she explained, going on to cite Nepali cultural norms that give men higher status than women as a reason for her respondents' actions. In this case it resulted, the women reported, in them preparing meals with more meat and cooked vegetables (rather than salad), as this was what their husbands preferred. Her conclusion, that her interviewees "are more directed to fulfilling their husbands' preferences than their own choice of food" was not so obviously reflected in my own findings. Contrary to Malla, within the Nepali households I got to know, I could find no particular evidence that male members' tastes were favoured or especially catered for over and above

those of the women or girls. My findings do show that children seemed to exert a greater influence over what food was available, but that the adults themselves did not always eat it. This suggests that in diaspora immigrant children's role as 'cultural brokers' in relation to family foodways was, in the case of my Nepali respondents, less definitive than either Malla's (2005) or Kumar and Ayub's (2010) work implied, and instead more in line with Ray's (2004) research.

Returning to the potentially gendered nature of foodways, discussed in the previous chapter, one way husbands' views may have impact on the household diet is when they are directly involved in the food shopping. Women may do most (if not all) of the food preparation in many South Asian households but anthropological studies in India have shown that men are often responsible for purchasing the food (Donner 2011), meat especially (Staples 2017). That said, work among middle class women from Chennai, found that with the growth of supermarkets, couples were often shopping together, and in one place special seating was provided "for the husbands" to wait while their wives actually made the purchases (Caplan 2002: 52). Among diaspora groups, Ray (2004) found working with Bengalis living in the US that women did nearly all the food shopping as well as its preparation. Malla's research in Norway, meanwhile, identified two of her (women) interviewees as usually "being accompanied by their husbands" when food shopping, although this was attributed to the women's lack of confidence with the Norwegian language more than anything else (other interviewees relied instead on friends with better Norwegian skills) (Malla 2005: 66). For the Nepali couples I encountered, however, food shopping was an apparently shared endeavour – both the woman and man could and would purchase groceries, often together doing a 'big shop' at the weekend for example, but also separately, depending on who had the time or would be passing the relevant shops. So, as touched on in the preceding chapter, we see that contrary not only to the Norwegian public health representations, but also to anthropological findings in relation to the food shopping practices of various South Asian groups (in their homelands as well as in diaspora), the Nepalis I worked with demonstrated an alternative way of being. There again, then, we detect evidence for the value of discriminating much more carefully than the simple (and simplistic) category of 'South Asian' could ever allow.

As detailed in Chapter 2, the Nepalis I encountered in Norway were quite a young group, almost exclusively first generation. Moreover most had either grown up in or near to major towns or cities, or attended school or college there. Thus although brought up with Nepali food norms, they had already been exposed to 'foreign' food and Western consumer culture, which was increasingly available and present in urban areas (most notably Kathmandu) from the 1990s (Liechty 2003). Upon coming to Norway, usually in their twenties or at most early thirties, and

there starting families, their dietary habits and practices while created in Nepal were not necessarily so firmly fixed, I would suggest. Consequently, as will be seen, a certain degree of accommodation to non-Nepali foods does not appear to have been too arduous a task for them.

In the sections up until now, then, I have sought to sketch out a range of factors that impinge on people's food choices beyond the oft-cited and often indiscriminately applied 'culture', which as we have seen is used quite widely within the public health research analysed in Chapter 3. Instead, I have demonstrated how technological change (refrigerators, for example), the environment (what is available to cook with), economics (the cost of food), social structural aspects (timings of the working day, childcare opportunities) as well as age and gender, all play into any consideration of foodways, and how the Nepalis I worked with negotiated these. In doing so, my aim has been to show the value of adopting a broad basis for evaluating dietary habits and practices within any group (immigrant or otherwise) if one is to gain a fuller picture and understanding of their foodways. That achieved, we will now turn to look more specifically at how the Nepalis I encountered perceived of food in relation to health and wellbeing.

Food in relation to perceptions of health and wellbeing

Before proceeding, it is important to note that very few of the Nepalis I interviewed reported having any chronic medical conditions that impacted directly on their dietary habits or practices. One woman had irritable bowel syndrome, she told me, which caused her to avoid certain foods that she felt worsened it (alcohol, caffeine), and another had a thyroid condition that because it was treated with thyroxine actually did not affect her diet at all. Thirdly there was Nirmala, who (as we will see in Chapter 6) had developed gestational diabetes during her pregnancy but this resolved following the birth of her son. This lack of conditions, Type 2 diabetes and cardiovascular disease in particular, which as the previous chapter shows are frequently associated by public health researchers with South Asian immigrant populations, is most probably attributable to the relatively young age of most of my respondents (the majority under 40 years of age).

Biomedical reasoning

Biomedically-based nutritional language and logics were invoked in every interview I undertook with Nepalis. As noted in the previous chapter, several of my respondents worked in the health and social services as doctors, nurses, care and *barnehage* assistants, were otherwise scientifically trained or worked in the catering trade. Moreover, others in none of those fields were often educated to university level. It must also be remembered that biomedicine and its correlates (i.e. public health, nutrition) have an established presence within Nepal, even if they are less well-resourced than in Norway and hold potentially less hegemonic sway (existing as

they do alongside a range of other medical knowledge systems). Consequently, it is unsurprising that the terms ‘protein’, ‘carbohydrate’ and ‘fat’ as well as ‘nutrition’ and the inter-relationship between these featured frequently within our conversations. Nirmala, an office administrator, on describing the food they gave her toddler son, Dinesh (“a little bit of rice with lentils, sometimes maybe fish, sometimes maybe chicken. And along with that, maybe carrot, celery, all the other vegetables, then cook it together. And the grind and give it to him”), concluded that “I think that will be a combination of protein and carbohydrates and everything he might need”. Others also framed their Nepali meals in such a way. Anil, for example told me: “Actually it’s a good combination. We have rice that means we have carbohydrate, if we have meat and vegetables then we get lots of nutrients and proteins and the soup [*dal*] is also rich in some protein”. Among the medically-trained Nepalis, Ram’s response was fairly typical: “We need a good amount of carbohydrate every day, everybody does. And we eat carbohydrate-rich foods such as rice, every, at least every other day”. On the subject of protein, “for the maintenance of our body, muscles and so on”, he and his wife, Prithi, included “protein-rich food”, such as “*dal*, beans, the pulses, eggs. We don’t eat meat every single day, maybe twice a week”.

A number of the Nepalis I spoke with told me that when they were shopping they actively sought out products marked with the *nøkkelhull* (Nor: keyhole) sign. This is a Norwegian Food Standard’s Agency-sponsored measure, whereby foodstuffs deemed as healthier options – those with one or more of “less fat and less saturated fat; less sugar; less salt; more fibre and wholegrains”, are marked on their packaging with a small green and white keyhole-shaped symbol (Matportalen 2015).²⁷ Everyday examples included wholegrain breads, reduced fat meat and dairy products and vegetables.



Fig. 4. *Nøkkelhull* symbol (Matportalen 2016a)

²⁷ From the Norwegian: “*mindre fett og mettet fett; mindre sukker; mindre salt; mer kostfiber og fullkorn*”. (Matportalen 2016a).

Meanwhile, the relationship between certain typically South Asian eating habits and diabetes was raised explicitly during the weekend gathering of Nepali female friends, organised by Indira at her apartment (and where the emergency *ghee* conversation that opens this dissertation also took place). Over plentiful Nepali-style snacks and food, the relative merits of rice and wheat were discussed and how, in Nepal, the twice-a-day habit of eating rice was giving way to once-a-day rice and once-a-day wheat- or corn-based food, either *roti* or corn porridge. Indira and Annie said that while wheat and corn flour were once “typical for those people who don’t have wealth” and rice for two meals a sign of those with “enough money”, “now it’s [eating wheat- or corn-based food instead of rice] been a good reason for health... for the diabetic patients and blood pressure patients you know”. Mira also chipped in, adding, “now the diabetes people, they start with brown rice”.

Alongside an appraisal of their diets along (biomedically) conventional, nutritional lines, there were also other ways in which the Nepalis I encountered described foods. Even in non-diaspora settings it has been shown that different food conceptions overlap (Khare 1986), and that apparently strict dietary rules within and between certain groups can be “dynamic and flexible” (Caplan 2008: 120). Binaries of ‘hot’ or ‘cold’ and also ‘heavy’ and ‘light’ featured in several of the conversations I had with informants, yet also ideas of relative ‘digestibility’ and, in one case, outright identification with Ayurvedic principles also occurred. These alternative accounts of foodstuffs appeared to co-exist quite fluidly with nutritional accounts in my interlocutors’ consciousness – a situation that ethnographers of immigrants to the UK have also found (Iranian – Harbottle, 2004; Punjabi – Bradby 1997, Homans 1983). Curiously, the topic seemed to have been consciously avoided by Malla (2005) in her work with Nepalis in Norway. Nowhere in the study was mention made of foods being perceived (by her or her interviewees) as either ‘hot’ or ‘cold, ‘heating’ or ‘cooling’: rather, in defining her description of food “condition” – as either “cold” or “warm” – she notes: “[I]n this study, the term warm food refers to recently cooked dishes which are eaten warm e.g. rice, pasta, vegetables, while cold food refers to dishes which are eaten cold and not necessary to cook before serving e.g. bread and bread spreads” (2005: 41). This absence is interesting given that such evaluations of food were made by several of the Nepalis I talked with.

Foods as ‘hot’ or ‘cold’, ‘heating’ or ‘cooling’

The ‘hot’/‘cold’ binary was by no means an overarching category for all the Nepalis I interviewed on the topic – friends and couples sometimes disagreeing about its relevance. For example, while Padma would avoid yoghurt and other ‘cooling’ foods and drinks when she had a cold, her husband Kamal would eat what he felt like: “in my opinion there’s no need to say ‘no, I cannot have that one’. I suppose, for me, if I get ‘flu, if I get cold, I take yoghurt”. At

Indira's gathering there was a similar divergence. One woman, Kusum, who was married to a Norwegian, had been resident in Norway for over twenty years and taken an anthropology course during that time, told me that as far as she understood the "the explanation lies more culturally than medically". She then said that while, "culturally-speaking", 'cold' foods would be avoided in cases of "colds or throat infection", 'hot' foods could actually aid the infection hence "doctors recommend 'cold' things, like coke and things". Some women around the table nodded in agreement but when I asked them what they did on an individual level, at least half admitted that yes, they did continue to forgo 'cold' foods and drinks, Indira saying that in her experience taking 'cold' things "just prolongs that [the problem]". Sonya, who had also lived in Norway for more than two decades, continued to apply aspects of the dichotomy, incorporating clove and ginger (both considered 'heating') into her everyday food-making, and explained the concept to me thus: "some of these things [foods] have particles that make it warmer, your body warmer". Sunil, meanwhile, offered a slightly extreme but interesting example of where the 'hot'/'cold' binary clashed with Norwegian medical health expectations, recounting a 'flu-like' illness he had the previous winter:

"I was waiting my turn to see the doctor, when I saw him he said 'have you eaten anything today?', then I said 'no. Why? I don't feel like it'. And he just said, 'go and have coca-cola, it can give you some calories'. 'I don't want to drink', I said, 'it will make me cold the coca-cola'. But the doctor said, 'no, it gives you some calories and some energy and you need energy. You are lacking energy in your body. Please go eat and drink'. But it is interesting; in my country we don't do that. Coca-cola itself is a 'cooling' drink. That is how the concept is. And I see that way. And when I am having cold the usual tradition in Nepal is we have to be warm."

These accounts demonstrate some evident overlap here between thermal and humorally-conceived notions of foods having 'hot' or 'cold', 'heating' or 'cooling', qualities. As already mentioned above, a preference for warm food over cold was retained by several of the Nepalis whom I encountered. That individuals could hold contradictory views of 'hot'/'cold' foods and mixed these with alternative explanatory models has also been reported elsewhere (Staples 2008), and accords with the findings of Caplan (2008) and Khare (1986) already noted. These alternative ways of assessing food's health-maintaining properties that were in active, if variable, use among the Nepalis I spoke with is of note in light of their absence in Malla's study (2005), yet also because of their considerable presence in the public health works discussed in the previous chapter. As we have seen, such alternative accounts are at times presented as obstructive to health personnel's efforts to change immigrant foodways. The appeal to non-thermal qualities in food was most evident in responses I received during conversations about

pregnancy and childbirth (see Chapter 6), and as these topics were not touched upon at all by Malla it may account for that lack of comment in her work. As Dawes's (2006) work with Pakistanis in Oslo makes plain, however, within other South Asian groups resident in Norway the 'hot'/'cold' binary continued to be readily employed in relation to foodways, not least with regard to the perceived ('heating') qualities of *ghee*. During my interactions with Nepalis, however, more evident than a 'hot'/'cold' dichotomy were the notions of 'digestibility' and food being considered either 'heavy' or 'light' (all of which featured in Khare's (1986) elucidation of the Indian meal as well).

'Digestibility' of foods

Digestibility, as a quality, was most often described in relation to children, the elderly and periods of illness, when food needed to be at its easiest to digest. *Jaaulo*, a rice porridge made with salt, turmeric and potentially some cooked vegetables or lentils was mentioned often by the Nepalis I spoke with as the most "digestible" and therefore suitable food to eat in such instances. Oily or fatty, spicy and raw or cold foods, on the other hand, were all considered to be less readily absorbable. Again, views among my informants on this varied and there did not seem to be the same degree of certainty surrounding proscriptions as cited in work among Pakistanis in Oslo (Dawes 2006) and Bangladeshis in the UK (Greenhalgh et al. 1998). No-one I spoke with, for example, described food becoming less digestible through baking or grilling (Greenhalgh et al. 1998) or steaming and boiling (Dawes 2006), or that food need necessarily be seasoned and cooked for a long duration to make it easier to digest (Dawes 2006).

Moreover, digestibility was often explained in nutritional terms. Shanti told me how during a recent illness in her son, she had avoided giving him meat and dairy products because these "needed more energy to digest". Nirmala expressed similar cautions: "so meat when you're feeling not so well, because it's, I think it's protein, it's very hard for the body to digest when you're ill, so I try no to eat. Maybe vegetables, and maybe some other light things". Ram, a medical research scientist, sought not to ally himself completely with his wife Prithi's assessment (to "avoid some more spicy, some oily food and eat as simple as possible. And hot... drink much hot"). Instead he asserted, perhaps rather predictably, "when I am unwell, I don't avoid any food but I try to eat less protein-rich and fatty food, so that it will make it easier to digest this food", concluding that "the body will not have to struggle much to digest this food". It is worth noting that Shanti also mentioned adding certain things in her cooking to help her son's digestion, notably *methi* (fenugreek), which she considered "important – he has it to help his digestion". She described mixing the spice into a pea dish he liked, otherwise it would be "too bitter" on its own. Sonya also ascribed digestion-enhancing properties to certain foods, especially ginger, which she often used, also for its aforementioned 'heating' quality: "ginger

helps you digesting and ginger makes you warm”. Thus a judicious use of certain spices, especially *aduwa* (ginger), *besar* (turmeric), *methi* and *jwano* (thyme seed), were believed by many of my respondents to aid digestion, even if spicy food was more generally described as being somewhat harder to digest. Passing reference to *fordøyelse* (Nor: digestion) was made by the Norway-based researchers Kumar and Ayub, who identified it as one of the “*dominerende temaene*” (Nor: dominant themes) within public health-sponsored focus groups aimed at investigating foodways among South Asians in Oslo (2010: 179), but no further examination of the concept was undertaken.

Foods as ‘heavy’ or ‘light’

Descriptions of foods being ‘heavy’ or ‘light’ occurred with even greater frequency and a slightly more stable level of agreement among my informants – most usually when speaking about rice. At the gathering of women friends organised by Indira, for example, she explained that while it was “not exactly healthy, when you eat rice then you can do things... It’s quite heavy and it stays for a long time”. She went on to make a contrast with bread: “two slices of bread and after just a few hours, after two hours it’s just over. And you feel like you are hungry again. But like rice, [it’s] five, six hours with the rice.” Jyoti and Anil stressed the grain’s importance in the evening thus: “every evening we have to have rice, otherwise you can’t sleep, we need a heavy diet in the dinner”. I double-checked with them that ‘heavy’ was a positive quality, to which Jyoti replied, “yeah good, you can easily sleep”. Similar checks I made with other respondents bore out this idea of heaviness as a largely beneficial characteristic, but there were some nuances regarding context and the evolution of people’s habits in diaspora.

Several of the Nepalis I interviewed told me that eating a rice meal in the middle of the day was now no longer preferable because it’s ‘heaviness’ made them feel sleepy, for example. Nirmala, who like many usually ate her Nepali meal in the evening, told me even when she had time to make one during the day, such as at weekends, she did not tend to, having “been used to eating ‘light’ food during the day, so you don’t really eat [a Nepali meal] then, because rice is very ‘heavy’ to have”. Malla (2005) too encountered the ‘heavy’/‘light’ dichotomy, her informants using it in much the same way as mine, contradictions between her characterisations of interviewees’ assessment of Nepali meals evident. In one place their energy-giving nature was asserted: “a heavy meal meant warm *dal*, *bhat* [rice] and *tarkari* [curry]. After having such meals they felt their stomach was full and they themselves felt energetic. Light meals meant those that were eaten in relatively smaller portion compared to the heavy meals” (2005: 58 – 9). Yet elsewhere, the somnolent effects of such meals were recounted: following Nepali meals her respondents “felt heavy and sleepy” (ibid: 73). Both instances offer further example of how perceived benefits can change with context and altered habits.

The binary of ‘heavy’/‘light’ also found uses beyond rice among those I spoke with. Ram and Prithi, for example, invoked it in describing their altered breakfasting habits since coming to Norway. Both defined their now usual meal of “yoghurt and muesli” plus “fruit juice and some baguette, butter and baguette”, as ‘heavier’ than it used to be, Ram explaining that “tea alone would make my breakfast back home [in Nepal]”. The characteristics of ‘heavy’ and ‘light’, when conferred upon food, thus seemed to imply sustenance and satiety. As Indira’s comments made clear, it did not necessarily connote health. Nonetheless, that certain foods, taken at certain times, made people feel they had either enough energy for their day or that the meal assured them sufficient rest, points if not to health then perhaps to a sense of wellbeing. Given the apparent malleability of defining foods, following Nichter (1986) I think it is useful to conceive of the apparent dichotomies of ‘hot’/‘cold’, ‘heavy’/‘light’ more as continua than discrete entities. Whatever the case, paying attention to such qualities as ‘heavy’/‘light’, as they are defined and applied within immigrant groups, is necessary if one is to gain a greater understanding of how they relate to their current dietary habits and practices. This is an understanding not aimed at negotiating towards biomedical imperatives, but rather something potentially informative to the host country as well: enabling a broader appreciation of notions of health and wellbeing in relation to foodways.

Applying Ayurvedic principles to dietary habits and practices

Although Ayurvedic principles could be discerned in the application of the ‘hot’/‘cold’ relationship by several of the Nepalis I spoke with, only one respondent, Ashok, explicitly mentioned them in relation to his dietary habits. “Because in our Ayurveda, these cold things”, he explained, “for my kind of health, I belong to that category [constitution] that I should generally avoid”, so he tended to “avoid ice cream... but yoghurt I like and so I take that out [from the fridge] an hour before in the cup and then I eat, not very cold”. Here, as with others, he appeared to combine both thermal and non-thermal notions of foodstuffs being either ‘hot’ or ‘cold’, milk-based products again featuring as prominent examples of potentially ‘cooling’ foods (see also, Nichter 1986). Still talking from within the paradigm of Ayurveda, Ashok went on to explain: “Your body is sincerely orchestrated from the cosmic correlates also, like seasons are orchestrated. So according to season you should eat something from it: sometimes mango, sometimes something else. In that sense, Nepalese food is different in different festivals, in different seasons; so that was somehow with that kind of Ayurvedic principles, so to say.” This second comment, although a little unconventional in its style of English, corresponds with explanations linking diet and cosmological factors (see for example, Khare 1986, Wujastyk 1997, 2003), and is interesting for suggesting yet further ways in which Nepalis – at home or in diaspora – might consider what they eat, when and why, in terms of achieving harmony within but also beyond their physical selves.

Fats: caution and appreciation

Anxiety about the types and quantities of fat being consumed by South Asians in the diaspora is, as Chapter 3 has made clear, an ongoing public health concern in Norway and elsewhere, and was a major focus of at least one Oslo-based study of immigrants (Dawes 2006). Moreover, as discussed, the existing Norwegian research generally seemed to suggest an absence of awareness or knowledge about the (biomedically-defined) risk of dietary fats among Pakistanis and Sri Lankans living there. In contrast, a large number of the Nepalis I spoke with were swift to voice their own concerns and attempts to reduce their dietary fat intake, justifying them in biomedical terms. Kamal, married with a young son, told me that when he cooked, in addition to using “less *ghee*” and “less oil”, he tried to use “olive oil” because “that’s good for health and everything”, and also encouraged his (Nepali) wife to do the same. Sanjay, meanwhile, had tried to adapt his cooking style: “I prefer to boil to reduce oil”, he said. On my asking him why, he had replied, “it could be a problem in health, you know. Heart and other things... it may increase the cholesterol in our body, so better to reduce”. Devi and his Norwegian wife, Ida, had made concerted efforts to improve their diet since becoming parents (their daughter is now eight). “We now have more focus on how much salt, sugar and fat”, he told me, the whole household using only skimmed milk and Ida and he preferentially buying *mager* (Nor: reduced fat) versions of other foods, such as the *pålegg* they used in their lunchtime sandwiches.

Others mentioned trying to cut down on their fat consumption to avoid gaining weight. “I like *ghee* but I don’t want to eat too much because it’s too fatty and if I eat every day then I get so fat”, Anil told me. His wife, Jyoti, had agreed, adding that since the birth of her second son, “I’m planning to lose weight... I have not even taken *ghee* during the pregnancy and after the baby”. Not everyone who limited their *ghee* intake did so for health reasons. Mira did not like the smell of it when cooking, so used it only sparingly. Sonya, meanwhile, returning to the notion of digestibility explained, “when you eat much [*ghee*] then it is difficult to digest”. Both continued to use it nonetheless, because of its good flavour, the matter of good or appropriate ‘taste’ something I will return to a little further below.

Certain fats, specifically *ghee*, were nonetheless also judged to be healthy in certain contexts. At Indira’s gathering there was quite some discussion about this. Most of the women present seemed to agree with Annie’s assessment that “it’s a difficult question, isn’t it? For us, we’re from Nepal, and we used to say that *ghee* is really good”, her friends nodding or murmuring their assent. Mira added: “I think it [*ghee*] is good for health but it is not everyday. We don’t use it everyday”, which met with similar accord. Through a mixture of voices it was then explained to me that for children less than five years of age, in Nepal “*ghee* is the most important thing”, thought to contribute to the building of muscles. This was particularly relevant

for families that were unable to afford meat and dairy products, this lack of “the vitamin- and mineral-rich foods”, as Indira categorised them, resulting in the use of *ghee* as “a compromise”. Nevertheless, as relatively well-off women now living outside of Nepal, many told me that they still continued to use *ghee*, especially in preparing food for their children. “I think everyone knows that research has shown animal fat is not good for health but it’s like in our head we have been taught it is good for health”, Annie reflected. This awareness of *ghee*’s contentious position in relation to health was perhaps best summed up by Indira in reference to her then four-year-old son: “I have to be two-way conscious: fat not too much because I have to make my boy healthy, but the other way [he] has to have muscles strong and all those things. That was what preoccupied my mind”. Further evidence of *ghee*’s significance to perceptions of health comes in the Chapter 6, where my respondents pregnancy and postnatal foodways are explored. For now, however, we can already see that the Nepalis I talked with were not only aware of but sought to incorporate the contradictory accounts of *ghee*’s ‘healthiness’ as best they could into their current, diaspora-based daily lives. In this way their experiences mirror those of the Punjabi women that Homans (1983) and Bradby (1997) worked with in the UK, in these cases biomedical and alternative food-related health beliefs shown to co-exist relatively fluidly.

Concerns about weight gain and obesity

Weight gain and obesity among South Asian immigrants is, as the preceding chapter has shown, a significant public health concern in Norway. Anil and Jyoti’s comments above show that control of their weight was something they also worried about and the subject came up in numerous other conversations I had during fieldwork. One time, joining a conversation between Nirmala her friend Ambika, both of whom were laughing a lot, I asked what was so funny. “We’re both trying to go down in weight”, said Nirmala, adding that she had been trying since giving birth to her son, “but the bigger I get, the more I feel like eating fatty food”. She admitted that she did not “move enough – I take the *T-bane* [Nor: metro] to work, sit all day, take the *T-bane* home, then play with my son”. Ambika had then added, “we also like food too much”, provoking more mutual mirth. During another chat, Annie told me that when she and her family have pizza, spaghetti or noodles then they sometimes have coca-cola. However, although she likes it, she tries not to drink so much her reasoning being that “if I eat so much rice, bread, pasta *and* cola I will become [she then gestured to indicate her sides widening considerably]”, chuckling as she said it.

At the get-together of friends arranged by Indira, discussion of weight gain or loss also had a humorous tone. Most there agreed that not being overweight was a concern to most of them, and when I had asked if there was something they stopped eating when trying to lose weight, several

voices at the same time replied, “rice”, followed by quite a lot of laughter at the futility of such a proposition, everyone around the table agreeing with Indira that “stopping rice would be most helpful but is also impossible”. Several of the Nepalis I met explained that while it had been traditional in Nepal to view excess weight positively, as a sign of relative affluence and, in children, also of health, this view was now changing, women in Nepal especially becoming more conscious of not becoming fat. Exercise classes were therefore increasing in popularity “back home [in Nepal]”. A few of the women I met talked about their efforts to go *trening* (Nor: exercising) now they lived in Norway, usually walks with friends or family in the evenings.

To what extent negativity regarding weight gain related to health rather than aesthetic sensibilities (or indeed whether my respondents even made a separation between the two in this way), I cannot say, although the impression I gained was that appearance was the greater concern. Malla’s respondents, interestingly, judged the weight they had gained in Norway along more positive, ‘traditional’ lines: “They considered gaining weight as a sign of good health, as putting on weight to an extent was related to good health, wealth and status in Nepal” (2005: 74). That said, several of them had experienced weight loss due to contaminated foods in Nepal, hence their evaluation of the benefit of weight gain was also tied to assertions of Norway’s better food hygiene standards (see Chapter 3).

As mentioned in the previous chapter, obesity among South Asians in Norway has been referred to as an “epidemic” (Kumar & Ayub 2010: 187, 188). Råberg et al.’s (2009) study of Pakistani and Sri Lankan men and women living in Oslo also found quite widespread “dissatisfaction” regarding their weight among its participants. Research with Pakistani women living in Oslo found “*problemer med å holde seg slanke i Norge*” (Nor: difficulties with keeping themselves slim in Norway) were apparently expressed by “*de fleste kvinnene*” (Nor: most of the women) (Kumar & Ayub 2010: 179). That said, these women recalled that in Pakistan the subject had not been such a concern; awareness of the problems of being overweight and weight gain as a frequent theme of conversation had arisen only once they came to Norway (ibid). From the way the Nepalis I spoke with talked about their weight, they did not seem especially ‘dissatisfied’. As shown above, there was recognition by some that they wanted to lose some weight but they appeared to be not unduly concerned about it. And while it is a very rough measure, I think it is worth adding that, based on external appearances, to my (medically trained) eye, none of the women – or men – I interviewed were obviously obese; some were admittedly on the plump side but many appeared to be of an average size. Moreover, those who were most probably overweight, such as Mira, Ambika and Nirmala, were also openly aware of the fact.

Climate, diet and health

Some of the Nepalis I met also articulated climate-related connections to diet and health, albeit rather non-specifically. During a conversation about his satisfaction with his current diet, Ashok's first response was to say, "yes, I think in my opinion our [Nepali] food maybe ok in those kind of climates, down there [in Nepal], but here Norwegian food is also healthy, you know". And as I was leaving, following a morning spent talking with Sonya at her home in a suburb a little outside Oslo, she sought to summarise her thoughts thus: "my conclusion in food is, the place where you are living, you have to adapt according to the climate. You can't live eating the thing you are eating in a warm place. They [are] used more to cool your body. But here [Norway] you need to have food to warm up your body". She then went on to suggest that not only diet but activities also needed to be adapted to: "Maybe you need more fat here. And if you just eat like they are eating here, so you have to do like they are doing here. Go sleek, go sporty and do lots of things [laughs]. I think that is, that can be a problem, that some Nepalis come here and they started eating meat, butter and these foods and they gain weight very quickly, because on the other side they don't do the exercise the same way they [Norwegians] are doing here".

Links between climate and weight gain had been made in Dawes's (2006) study of Pakistani women living in Oslo, digestion and more general notions of bodily balance held to have been disturbed by moving to a colder climate. A particularly clear example came from her respondent, Shazia: "This is a cold place and we don't move around much, keep sitting inside the house, sweat is not released" (Dawes 2006: 28). This, Dawes explained, by drawing on the logics present within both Unani-Tibb and Ayurvedic medical systems, whereby the need for a flow of substances within and between the body and the environment is asserted (Helman 2007; Leslie & Young 1992; Wujastyk 2003). Thus balance (and hence health) of the body is achieved through balancing the humours within the body, as well the body within its environment. Diet but also adequate emissions, including sweating, are therefore necessary to maintain appropriate equilibrium and hence health.

While neither Ashok nor Sonya made specific reference to sweating or balance, their comments evidently relate the significance, in their opinions, of foodways to climate. They were among the most long-settled in Norway of all the Nepalis I met during fieldwork, each having lived there for more than twenty-five years. So while accepting that they were only two among the many Nepalis I spoke with, their extensive exposure to and experience of dietary adjustments in a Norwegian setting suggests their views are noteworthy.

Taking this section as a whole, exploring the various ways in which the Nepalis I worked with linked notions of health and wellbeing to their foodways reveals how they used their own individual experiences and perceptions to reach apparently satisfying dietary habits and practices now they lived in Norway. Traces of Lévi-Strauss's (1972) 'bricolage' are once again discernible within their foodways – my respondents drew on what they knew and believed, as well as what they had access to, to improvise structured, personalised responses. This speaks, in turn, to a key contention of this chapter: the value of recognising how the Nepalis I encountered moved between biomedical and other understandings of diet in relation to health, and the significance of this to challenging the dominant readings of foodways and immigrant health in Norway that are based so firmly (and narrowly) within the biomedical paradigm. As we will now see, moreover, taste and satisfaction were also of great importance to my Nepali respondents, and although not explicitly connected by them to health, could be seen as contributing to their expressions of wellbeing.

Taste and satisfaction

Khare's (1986) anthropological study, 'The Indian meal', makes clear that satisfaction regarding one's diet is, alongside health, a key consideration for many Indians. Both taste of food and satisfaction with current food habits and practices were factors often interrelated in my Nepali informants' responses as well. There was a widely held perception that, as Nepalis, they liked 'tasty' food; Norwegian (and other western-style) foods were, in comparison, considered bland. Many therefore practised foodways that walked a line between the two. By eating a largely Norwegian-style breakfast and lunch, then a more Nepali-style evening meal (which, as we have seen, for some might mean simply 'spicing up' a pasta dish), both culinary styles could be incorporated, in personally satisfying ways. Ashok, whose own eating habits followed this pattern, summed it up thus: "we want very tasty, so in my case I have combined these two kinds of tradition [Nepali and Norwegian], I feel like I am really, I eat really good food every day", he went on to give an example of how he does this even with his ostensibly non-Nepali meals: "of course, even if you call it Norwegian, even if you are making something, salad or something, we can put some spices or something in it, so it is a little more tasty".

The trope of 'taste' extended from individual ingredients, to meals in general. The lack of flavour of vegetables available in Norway, as compared to Nepal, was a frequent comment: "they look fresh but they don't taste so good as in Nepal" was Annie's view, for example. While invariably privileging the flavour of their native cuisine over Norwegian (or other) examples, the Nepalis did not appear to idealise Nepali food to the same extent as, for example, the Bengalis Ray (2004) worked with in the US or the Iranians in Harbottle's (2004) research, where both researchers encountered more overtly expressed disdain for American and UK

culinary cultural practices, respectively. More generally, the Nepalis I met also identified spices (as well as *ghee*) as the means through which Nepali food achieved its particular tastiness, albeit with some possible risk. *Ghee* gave a “correct taste” but, as we have seen, could be thought unhealthy or indigestible. Spices, meanwhile, gave good flavour but were potential causal agents of digestive upset, “gastric” (indigestion) in particular, chilli the main culprit. Kamal’s statement captures very well the sentiments of many I talked with: “Too much spices is not good. It’s a good taste, but it doesn’t help your stomach”.

As we have seen, however, some of those I spoke with – Sonya and Shanti, for example – used spices such as ginger and fenugreek to help with digestion; Sonya moreover, maintained that cooking spices in certain ways, especially frying them, although it “gives a good taste” made them “harder to digest”. As fieldwork progressed, I subsequently became aware of a generalised differentiation that was never formally articulated: between ‘too much spices’ which effectively referred to chilli and especially potent *masalas* (mixtures of ground spices); and ‘spices’, those additions that provided necessary flavour and potentially health-enhancing effects, ginger or fenugreek, for instance. Accordingly, a rather more nuanced appreciation of the Nepalis’ understanding and use of seasoning began to emerge, one where a balance between taste and wellbeing was the aim.

Anil, admitting that he was partly joking with me, posited an additional theory that “if we use more spices, we eat more... you know, more Nepalese they have big bellies”. Laughing, he had then corrected himself, “no, no, no. It’s because of different things. If you’ve grown up in the same place, for example my son, he likes to have Norwegian food, he likes very much but because he is used to this taste. But we”, gesturing to himself and his wife, Jyoti (who was seated next to him), “are from Nepal and we have already Nepalese taste in our tongue, so we have always preferred, we are always looking for that taste”.

This invoking of one’s tongue to explain taste preferences was something I heard from other Nepalis too. Over dinner at his home, Nayan, a doctor, told me that “for the tongue” he would eat Nepali food but “for the body” he would eat Norwegian food, because it has “less fat” and is “more balanced”, Norwegian meals in his experience usually “one-third salad, one-third carbohydrate, one-third protein”. He was, he said, trying to impart this (inherently biomedical) attitude to his elder son. The boy currently preferred slices of processed meat “but this doesn’t contain that much protein in it”, Nayan continued, “so I am telling him that ‘you should eat for your body, not for your tongue. Don’t just eat what your tongue says. You should love your body. You need more protein to build your body’”.

The vast majority of Nepalis I met expressed satisfaction, often seemingly unrelated to health, with the way that their eating habits had evolved following migration to Norway. Through certain pragmatic shifts accompanied by imaginative spicy tweaks to less perceptibly ‘tasty’ foods, they had found ways to eat that satisfied them. Certainly they missed some foods from Nepal but – as already mentioned – this did not hinder their enjoyment of the food in Norway. Annie, for example, said that while she “preferred rice two times a day” when she first came to Norway, she “soon adapted and now I don’t want rice more often than we have it”, which was “four or five times a week”. At the end of interviewing Anil and Jyoti, meanwhile, they both reflected on an effect of my questions. Jyoti had told me that they, “make us more conscious of our food habits”, how they had changed over the year, and that she had not really noticed because it had happened “so slowly”. Anil agreed, adding, “although we don’t feel we change our habit” in fact it was “slowly changing every day”. He then recounted how, during a recent visit back to Nepal, his mother had made him a rice meal in the morning and he had had to tell her that he did not want it. Instead he actually preferred bread and went out to buy some. Taken altogether with the examples given earlier of how the Nepalis I encountered had altered their foodways since coming to Norway, I think these point to a gradual and largely positive accommodation of the changes moving to Norway has brought to their eating habits and practices. This contrasts somewhat with the public health research discussed in Chapter 3, where there was little sense that respondents were particularly content with the dietary adaptations they had made. Although it should be added and as already stated, several of those studies featured people with Type 2 diabetes or other other conditions associated with particular diets.

Satisfaction was also framed by the Nepalis I met in terms of having the capacity to act on choices and preferences: “I’m really satisfied”, Sanjay told me, adding that “if I like to change, then I have money, I earn money, I can change easily”. Anil was similarly content. When asked if he would like anything to be different he was clear he would not: “No actually, because we are not doing because of others. It’s our choice. So if we don’t like, for example if we don’t like to make rice tonight, we can go outside to a restaurant, or we can just buy some pizza and burgers and have it... what we are doing we are satisfied with in this system”. Mira, meanwhile, drew a careful distinction between satisfaction and health. Eating rice, *dal* and meat and vegetables in the Nepali style made her feel “satisfied” and well in herself, but she was not sure that necessarily made it “healthy”. She also “felt better”, she said, for eating warm meals rather than cold ones, but did not think cold meals themselves were “unhealthy”. As we can see, therefore, taste and satisfaction were highly relevant to my Nepali respondents when it came to them feeling content and, I would suggest, well, in terms of what they ate and drank. Consequently, such factors fall squarely within any attempts to understand and evaluate the

foodways of a group in terms of health and wellbeing – something anthropological methods make clear, even if the existing Norwegian public health and biomedical research surveyed pays them ultimately little regard.

Food standards and hygiene

As we can see, the Nepalis I encountered also spoke of their current food habits in terms of hygiene. And many tended to compare the relative health of Norwegian and Nepali diets on the grounds of contamination risk or other factors, including nutrition. This was not unique to Nepal; Caplan, for example, recounts similar concerns among middle-class consumers in Chennai that made them more predisposed to buying “elaborately packaged” goods, seeing them as a better guarantee of quality, “especially hygiene and lack of adulteration” (2002: 60). Regarding contamination, over the course of fieldwork I heard many examples of how it was apparently common that food in Nepal could be adulterated in some way. Stones mixed into rice and lentils, powdered substances added to flour or spices, sugar mixed into honey, chemicals added to cooking oils, poor-quality meat because it was bred at accelerated rates (enabled by the uncontrolled use of antibiotics), vegetables on which excessive volumes of pesticides were used, and similar variations on these themes featured in a lot of the conversations I had with my respondents. The lack of cleanliness in Nepal’s markets and street food stalls was also mentioned. “In Nepal we are very much concerned with hygiene... hygiene maintenance”, was how Indira phrased it, and most agreed that there was significant “corruption” and very little “quality control” surrounding the sale of foods in Nepal. Several of those I spoke with described having had periods of illness in Nepal, which they attributed to poor food hygiene. Pinkee recalled episodes of stomach upset after eating meat there, which she attributed to “bacteria” in the meat. For Kamal, meanwhile, “from September to November, at that time I used to get like bitter water in my mouth because there is oil that is all not good. We have old [oil] that is mixed up. But here [Norway], I never get this sickness”.

Food standards in Norway, by contrast, were considered high, the Norwegian state (unlike the Nepali one) perceived as trustworthy, not permitting any low quality produce to be put on sale. Many therefore gave apparently little thought to such contamination concerns now they lived (and shopped for food) in Norway. At the time of fieldwork, politicians in Nepal were in fraught and protracted negotiations to draft a new constitution, following the bitter and brutal civil war during the preceding decade, from 1996 until 2006 (Mocko & Penjore 2016). Several of my respondents made reference to the relative stability and reliability of the Norwegian state when compared to the ongoing constitutional wrangling and evidence of significant corruption surfacing within politics in their homeland. And where these comments were related to food, it

offers a useful illustration of how political developments and perceptions of statehood can shape attitudes and habits surrounding comestibles.

A few of the Nepalis I encountered expressed concern about possible differences in standard between supermarkets and the *innvandrers butikker* and tended, consequently, to favour “Norwegian stores”. “We have more trust in the quality control”, one couple explained. These were in the minority, however. Most people I spoke with chose between the two types of stores based on the foodstuffs’ availability and price in each. Nirmala, in the following quote, offered a fair representation of many: “They have one Pakistani shop there [in the local shopping centre] where we can buy maybe the vegetables, rice, potatoes and everything. And for the bread and everything, we usually go to the Norwegian shop”. Another time we met, reflecting on her experience of having lived both in Nepal (until she was a teenager) and Norway (for the past twelve years), she offered an illuminating description of how her norms had shifted. Having now “lived away from Nepal”, she said, “you see the difference: what is hygienic, what is unhygienic”, so while there were some things she ate growing up there “without a problem”, those same things “I now don’t dare to eat” when she goes back to visit. Annie and Indira, who were also present, agreed, giving the examples of *bel phoori* (a popular street-food snack), milk, ice cream and *momos*. A couple of those I interviewed did offer an inversion on this general pattern, however. Fruit that was available year round in Norway was not only judged “less tasty” than in Nepal, but raised questions about “preservation” techniques, one woman openly wondering about “the chemicals” required to keep the fruit on sale in Norway so long-lasting. On this topic of food hygiene and contamination, my findings very much reflect those of Malla (2005) from ten years earlier – her interviewees also expressed similar concerns regarding foodstuffs in Nepal, yet confidence in the safety of those on available in Norway.

The Norwegian diet: healthier than the Nepali one?

Alongside perceptions that the food was safer in Norway, hence healthier, I also encountered assessment of the Norwegian diet as more healthy within biomedical parameters. Again invoking nutritional terms, the Norwegian diet was variously described as containing less “fat”, fewer “calories”, being “more balanced” and Norwegian people more “conscious of fibre”. Cooking styles were implicated by some: the fact that there was not so much “fried food” in Norwegian foodways was a good thing, according to Kusum. Anil, meanwhile, explained: “if we make a curry, we just cook it until well done, you know, until everything is smashed (*sic.*). But in Norwegian, not only Norway but in European style, you just boil it or fry little bit. So I think this is more healthier. Norwegian food is more healthier I think”. This attitude could suggest an objective kind of distinction on the part of some of my respondents, in this case based on nutrition. On the other hand, it is also possible that it spoke to a desire to appear more

‘modern’ or socially upwardly mobile within a framework where Nepal is cast as backward/traditional and Norway posited as forward thinking/modern. I will return to this point at the end the section.

For other Nepalis I spoke with it was the greater range of foods on offer in Norway that made the diet healthier: “I think the Norwegian diet is healthier than the Nepali diet... it combines rice, noodles, bread and potatoes... [in Nepal] the same types of food are eaten... In Norway you have more choices than in Nepal if you would like to eat healthy food”, was Annie’s view. According to Mira: “In Nepal, even if you have money, you cannot buy good food”. Both these statements are interesting for implying the personal agency of the shopper in making ‘healthy’ choices. It is not necessarily that the Norwegian diet is considered intrinsically healthier, rather – and relating back to issues food quality and contamination – that it is simply easier for more people living in Norway (than in Nepal) to access healthy food regularly.

Other respondents, however, were more even-handed, attributing health-giving aspects to Nepali cuisine as well. Some, like Maya, also used nutritional terms to make their case: “Nepali food is also balanced. Nepalis eat a little more rice than other things but it’s also a balanced diet. It has protein, carbohydrate, also vegetables and meat also”. In expressing her view she was, in fact, contradicting a prior assertion made by her husband, Nayan, that “the Nepali way is not that healthy way, I think”. This is the same Nayan, shown above to have favoured a Norwegian diet “for the body” – the exchange one more example of how different views about Nepali food often co-existed within the same household (and sometimes in the same person). That said, recalling Mira and Annie’s comments that it was possible to eat more healthily where they lived now, Maya agreed (with their statements, and her husband) that there was “more healthy food in Norway”.

Certain Nepalis were nevertheless clear about the potential merits of at least some of their homeland’s foodways. “I find in Nepali food some healthy things... vegetables and lentils”, was Shanti’s verdict. Rice, she went on to say, was “not so healthy” if eaten in excess as it was “mostly carbohydrate” and also because in Nepal “we tend to eat white rice”. Conscious of this, she now mixed white and brown rice when preparing it as part of a meal. Spices, as already discussed, could also be an area of contention when it came to health. Norwegian meals, which usually feature very little in the way of seasoning, were therefore judged by some to be ‘healthier’ (although inevitably less ‘tasty’). Sonya described it thus: “I think that in Norway they don’t use spice at all. They use a little salt, and butter, lots of butter, and somehow its healthy, healthy food, but you get tired of it”.

Returning to the point I raised above – that there could be an element of consciousness about being considered ‘modern’ in my respondents’ ascription of greater healthiness to the Norwegian diet – while none of the Nepalis I worked with articulated the connection themselves, I think there is scope to suggest that it was present. Given the particular background of my respondents, clearly outlined in Chapter 2 (their high levels of education and evident middleclassness), the aforementioned remarks that Norwegian foodways were ultimately ‘healthier’ (even if less satisfying for some, such as Sonya) presented my respondents as learned and critical appraisors of their food-related cultural practices, and hence seemingly more ‘modern’ and obviously middle class. It should be added, however, that the comments like Maya’s, which sought (within biomedical terms) to assert the potential healthiness of Nepali foodways as well, at the same time reflect a possible ambivalence associated with living in diaspora and the dietary options and opportunities that that brings.

Health, habit and the happiness of eating together

Eating what you are used to was regarded by at least some as important to maintaining one’s health. For student and bachelor Sunil, eating “my own country’s food, which is my everyday meal”, was what he thought helped to keep him healthy, together with sticking to his parents’ advice to drink milk (“milk is part of like being healthy”) and have fruits (“Like apple and banana. I mostly buy them regularly”). Puja, married but also a student, again gave a thoughtful response, telling me that while she did think Norwegian food was healthy, it was not her “eating habit”. To eat Nepali food was her “eating habit” and doing that made her feel “well”, and she did not think she would feel so well if she ate a more Norwegian diet. She then commented, “Nepali people don’t like to eat other types of food” and that many, if they “don’t eat rice within two days”, then “they do not feel well”, laughingly identifying herself as one of them. Nirmala, meanwhile, saw it more as a combination of moderation, habit and variation: “For me everything has a limit. If you take it within the limit then it is healthy. But if you take too much of it then it is not healthy”. She went on to give an example: “ice cream every now and then, actually ice cream does me good, like psychologically or something... I love ice cream. But if I take too much of that it’s not healthy for me”. Summarising her view, she told me, “Normal food that we usually have – a little bit of rice, a little bit of *roti*, have a little bit of variation in food. You know I think that is also very healthy. Not that you have the same thing each and every day”. Finishing her thought, she added “and I enjoy going out, having dinner together with my family. Maybe once in a month we can go and have dinner, maybe have lunch at McDonalds. That makes me happy. That’s some quality family times”.

This linking of health, happiness and eating together with others that Nirmala makes, is something that through my fieldwork encounters with Nepalis – especially over dinners, at

social gatherings, festive occasions, and at the Nepali school – I came to think of as a significant factor surrounding notions of wellbeing. Ashok gave a particular articulation of this idea:

“For me important in our food culture is how everybody else will enjoy, by talking and that. That other things adhere to food culture is also important... when they eat in a group and so on. They enjoy. You can’t even distantly imagine what kind of resonance is going on while eating”.

He returned to this theme a couple more times during the conversation:

“What is most important is not food as such, ok. It is the feeling around it, you have while cooking, while eating. Your emotion, your feeling... also your sense of gratitude, this arrangement of this food, you know. If you eat with these feelings that is the first thing for me to remain healthy”.

He went on to say that he had recently read of the large number of people in Norway who are off work, claiming sickness benefits, declaring, “it’s not because of the food. We have very good food here. Extremely good food is available. It’s something else”. He then drew on biomedical concepts to elaborate: “for eating with joy and talking, the endorphin is going”. In contrast, eating with “loneliness” and “worrying”, there “the endorphin is not going on, cortisol [a hormone indicating stress] is going on really”. Thus, drawing on other factors which he related to health, and in comparison to the Nepali diet, he characterised eating habits in Norway thus: “Norwegian [food], on the other hand is less spicy and good for the health. But cold and all the time keeping in the fridge, eating alone and thinking ten different things in your head. That is not good”. We can see that the social and spiritual elements of eating, for Ashok at least, were a necessary part of what contributed to whether or not he considered food as healthy. That these factors somehow ‘resonated’ within the individual, influencing to some degree the sort of nourishment they might receive from what was eaten.

At Indira’s gathering similar sentiments were acknowledged by Kusum, who said that she thought of Nepali foods in “two different perspectives: cultural-wise and healthwise”. “Healthwise”, she said, food with “lots of calories and fat” was not so healthy. “Cultural-wise”, however, gesturing over to the kitchen area, where pots and pans lay holding the remains of the (scrumptious) Nepali meal Indira had earlier prepared, the “gorgeous and delicious” food we had been eating, together with “people and their friends” (for whom it was “usual to serve delicacies” and “a volume of food”), this was all “healthy”. “Yes, this is the culture – very good, delicious food”, she reiterated. Alongside Kusum and Ashok’s comments, the feeling I

got attending Nepali events was that the food achieved significance in part because of the context. By itself the food could be specifically Nepali or not, quite simple, very special or somewhere in-between, yet it was in eating alongside fellow Nepalis, enjoying their company, that the food was perceived to gain additional value. This accords with Helman's (2007) observations on the social role of food more generally, values and relationships between those present restated and recreated through the sharing of food, meals in particular. Moreover, by some, such as Ashok and Kusum food could become in some ways even more healthy. This contribution of commensality to the physical as well as social development and wellbeing of a person, is also found elsewhere in the anthropological literature (Carsten 1997; Fischler 1988, 2011, for example). Fischler (1988) developed a concept of 'incorporation', whereby ingested food has physiological and also ideological functions, transferring culturally-ascribed values to the consumer, while at the same time assimilating them into the particular culinary system and culture: 'you are what you eat', in other words (Fischler 1988: 279 – 82). What is eaten, therefore, is of profound meaning both in terms of physical wellbeing but also social-cultural position and belonging. This concept is especially well illustrated through Carsten's (1997) work with a Malay fishing community. From her respondents, Carsten learned that a person's blood was considered to be continuously being formed yet also transformed through the consumption of food – especially steamed rice, which connoted a meal (ibid: 59 – 60, 108 – 9). Therefore, through the day-to-day eating together of meals prepared within a specific house, people were deemed to develop a "shared substance" (ibid: 127), the process effectively "creating connectedness between kin" (ibid: 108). Hence with respect to children, still very much in the process of becoming full members of the community, this physical as well as social (trans)formation was considered crucial in cementing their ties to siblings and other kin, and the taking of meals by children in others' houses was thus strongly discouraged: "Living and eating together are essential to the process of physical and emotional development. Those one lives and eats with, as well as the food eaten, have a crucial effect on who one becomes" (ibid: 60). None of the Nepalis I encountered communicated their dietary habits and practices in such blood- (or other substance) related terms. Yet considered alongside the examples of Fischler and Carsten, the additional regard for commensality and good company expressed by my respondents act to nuance our lay understandings of health, showing that they can clearly go beyond biomedical evaluations even when, in this case, they are also fully informed by them.

Nepalis in Norway *do* differ from other South Asian immigrants

A clear question arising out of the findings from this and the previous two chapters is whether or not all South Asian diaspora populations to Norway face the same challenges or issues regarding foodways. Through considering education level, household structure as well as which household members prepare the food, I have shown that the Nepalis I encountered in Norway

did differ from the other South Asian immigrants so-far studied there. As already discussed in Chapter 2, Nepalis living in Norway represent a relatively ‘elite’ yet growing section of Nepali society – the urban, middle class. In contrast, the majority of Pakistani immigrants to Norway came from relatively rural areas (Fagerli et al. 2005) and, as has been highlighted elsewhere (Dawes 2006 – see Chapter 3), often demonstrated limited educational attainment.²⁸ Within public health research, relative educational levels have been linked to the adoption (or otherwise) of nutrition-based logics and practices (Dawes 2006; Fagerli et al. 2005). Clearly, the longer one is in education, the greater the likely exposure to such information – the globally hegemonic position of biomedical accounts of nutrition ensuring this is the case, almost wherever one is raised. Given this context, the widespread and regular understanding and use of nutritional terms and concepts among the Nepalis I spoke with, and their less consistent or frequent application of alternative accounts of foods’ qualities (the ‘hot’/‘cold’ and ‘heavy’/‘light’ binaries, as well as notions of digestibility) seem comprehensible. The greater credibility they often gave to nutritional accounts, especially in discussions about fats and the assessment of the relative health of Nepali and Norwegian diets, also accorded with this – and reflected similar findings from the immigrant-focused anthropological studies of Bradby (1997), Homans (1983) and Harbottle (2004).

The pressures of having to provide food for a large household (and responding to the demands of specific members, notably husbands and children) have been cited by public health research in Norway as a significant factor in preventing Pakistani women there from being able to prepare ‘healthier’ meals – i.e. less fatty, less likely to contribute to the development of diabetes – meals (for example, Dawes, 2006; Kumar & Ayub 2010) . Yet from my findings within the Nepali context, where (as stated in Chapter 2) I knew of no households where more than two generations lived together permanently, it seemed that such pressures were relatively absent. Referring back to Jyoti and Anil’s comments on the subject, they related feeling at liberty to eat what they wanted: “we are not doing because of others. It’s our choice”. Puja, meanwhile, expressed it thus: “Here in Norway we eat when we are hungry. We eat whenever we want to

²⁸ As mentioned in the previous chapter, equivalent disparities have been observed between potentially (even more) similar-seeming South Asian immigrant groups elsewhere. Ballard’s (1990) work with Punjabis migrants to the UK, for example, traced the very different trajectories in diaspora (related, at least in part, to education and whether rural or urban-dwelling in their homeland) of Pakistani Muslims from Mirpur and Indian Sikhs from Jullundur, even though little more than two hundred kilometres separates those two towns.

eat, whatever we want to eat. If we feel hungry, we eat”. She contrasted this with Nepal, where “we have to wait. For example, if the father is not home, the families have to wait to eat”.

An additional divergence between my own findings and those of Malla (2005) and Ray (2004), is in relation to food preparation. Within the households I got to know, both the men and women were active in preparing foods – for all members. Ray, in contrast, found that “that middle-class Bengali men are particularly unskilled at cooking”, and so in the households he researched it remained (as back in Bengal) “a largely feminized task” (2005: 116 – 17).

Availability of time, rather than gender, appeared to be the determining factor in Norway. As already mentioned, many of the Nepali women I spoke with either worked or were studying, so if they were busy with either of those then their husband could – and would – make the meals. Even in cases where the woman did not work, although they tended to do more of the food preparing, there were still times when the men would make their own food. Both Kamal and Arjun, for example, did shift work within the catering trade, so often prepared (and ate) food at different times from their wives, Padma and Puja. Similarly, Annie, a nurse, also did shift work, so her husband, whose job had more regular hours, “usually” made most of the meals for the family during the week; and Devi also made more of the meals than his Norwegian wife, Ida. Consequently, the emphasis within the Norwegian public health studies, which the previous chapter has shown focus on the significance of educating immigrant women to effect nutrition-based dietary changes in the household more broadly (Dawes 2006; Kumar & Ayub 2010; Mellin-Olsen & Wandel 2005; Råberg Kjøllesdal et al. 2011), may have been somewhat overstated. While potentially of relevance to Pakistani groups in and around Oslo, among the Nepalis I encountered it fails to take into account an apparently more balanced division of food-related labour that already existed within many households. The findings presented here, therefore, also expose the gendered attitudes, and hence stereotypes and subjectivities evident in the Norwegian public health research discussed in Chapter 3.

Differences in opinion regarding the relative merits of certain foodways-related practices came up within several of the Nepali households I encountered. It usually arose where the man had a medical training and referred to it in justifying his nutrition-based conclusions. Nayan, Ram and Indira’s husband, Ravi, expressed incredulity towards some of the more Nepali-style foodways, and to certain postnatal practices in particular (see Chapter 6). Explicitly grounding their reasoning within their scientific training (“as a doctor, I don’t believe in those kind of things, I don’t see any meaning in them” and “I believe in scientific explanations, evidence-based, this tells me what is true” are two such examples), they invoked biomedically-based accounts of nutrition and made regular reference to ‘carbohydrates’, ‘proteins’ and ‘fats’ when talking about diet.

Women, on the other hand, even those such as Annie and Maya who both had medical training, seemed more willing to countenance the co-existence of not-necessarily complementary ideas surrounding a given food's health-related properties. This was perhaps most obvious in the aforementioned discussions of *ghee* – the need to be “two-way conscious” demonstrating that for the Nepalis at Indira's gathering, *ghee* maintained a perceived health-promoting value quite apart from its (openly acknowledged) identity as a fat. The significance of *ghee* to health is even more prominent in relation to childbearing, as will be seen in Chapter 6. Thus within several of the couples I interviewed different views on foodways were openly expressed, and in some cases different habits followed within the same household (Mira and Maya, for example warmed any bread they themselves ate; Sonya did not eat meat, although she would prepare it for her husband and daughter).

The clear comprehension of nutritional ideas by the Nepalis I encountered and their incorporation of these into daily life, in conjunction with an apparent acceptance of variably alternative accounts of foodways and health, points to them exercising a considerable degree of personal agency within their dietary habits and practices. Taken together with their seemingly adequate incomes and by then ready availability of ingredients (at least in Oslo and nearby towns such as Ås), this meant they could, on an individualised basis, incorporate various understandings of food (biomedically-based concepts of nutrition, the dichotomies of ‘hot’/‘cold’ and ‘heavy’/‘light’, notions of ‘digestibility’, considerations of climate and personal taste) that were not only personally meaningful but also readily workable within their households. Thus the great majority of Nepalis I spoke with were able to assert their satisfaction with their current dietary habits and practices as well as newly-adapting foodways, markedly different though they often were from those followed when they lived in Nepal.

Conclusion

This chapter neither presents a comprehensive delineation of how Nepali foodways have altered following migration to Norway nor asserts one way or another whether they are more or less ‘healthy’ than Norwegian (or any other) dietary habits and practices. Instead, drawing on the information and impressions gained from time spent with Nepalis living in Ås and Oslo, I show some of the ways in which these Nepalis utilised both biomedical as well as other metrics of health when making connections between what they consumed and resultant feelings of wellbeing. At the same time, certain dietary habits and practices of this particular South Asian group, a topic so far little studied in diaspora, have been related to relevant anthropological works as well as current public health research and debates within the host country (in this case Norway).

My aim has been to expand upon the picture currently presented within ongoing public health debate surrounding the diets of South Asian immigrants to northern-hemisphere nations. In Chapter 1 as well as the preceding chapter, examples from existing public health research make clear that much of what is written about South Asians, especially in Norway, in fact refers rather specifically to Pakistanis; additional, more anthropological and largely UK-based research discussed, meanwhile, addresses Bangladeshi, Punjabi and Chinese and Iranian immigrants. Accordingly, Nepalis – who are also considered South Asian not only in geographical terms but also, albeit tacitly, in biomedical and public health ones – may easily be subsumed within this category, and certain foodways and foodway-related attitudes ascribed to them. In Norway, where they currently number just under 2,000 – in contrast to the more than 42,000 Pakistanis, nearly 17,000 Sri Lankans and over 19,000 Indians (SSB 2016a) – this is particularly likely.

The above discussion shows, however, that while bearing notable similarities to other South Asian groups in diaspora (the eating of less rice and vegetables, and more meat, for example), the Nepalis I encountered in other ways appear appreciably different, for example through their ready acknowledgement of the dietary shifts they had made, their varying – sometimes hybrid – application of humoral and other, non-nutritional qualities to foodstuffs, and their satisfaction with their ‘new’ eating habits and practices. And especially, it must be noted, from the Pakistanis who, as already mentioned, comprise the most intensively studied (and therefore written about by public health researchers) South Asian immigrant group in Norway. Put another way, the Norwegian public health research talks about South Asians, but the Nepalis I spoke with and describe here demonstrated some evidently different attitudes and behaviours from the Pakistanis as represented by Kumar and Ayub (2010), for example. Once again, then, we can see the value of disaggregating the category of ‘South Asian’ within diaspora-related research, and hence further evidence in support of this thesis’s first key argument.

Although mine was a relatively small-scale investigation, I would suggest that it gives a more balanced account of the role of gender in Norway-based Nepalis’ eating habits and practices than the only other existing study of Nepali foodways in Norway (Malla 2005). Furthermore, my findings make plain the narrow view promulgated within nutrition-based biomedical and public health discourse surrounding South Asians in diaspora. While admittedly unevenly expressed, the evident value to wellbeing I heard my Nepali respondents accord to the circumstances surrounding eating, specifically the significance of being in good company, was one example of how broader considerations than merely the nutritional might be regarded as shaping overall health. Such factors, while encompassed by many of the ethnographies mentioned above, appear to fall firmly outside the remit of the more public health-focused, Norway-based enquiries that feature in the preceding chapter. And yet their presence within

some of comments from my informants, linking foodways and health, shows them to be relevant and, moreover, inextricable. It is precisely this sort of widening of gaze when it comes to evaluating perceptions of health, which I have tried to address through this piece of research. In doing so, moreover, I speak directly to my second key argument: the hegemonic yet limited nature of the biomedical model of nutrition in relation to health in Norway. My response, through this chapter and the preceding one, has thus been to make clear the significance of recognising the dynamic but potentially subtle, individualised yet sometimes inconsistent movements between various medical paradigms that the Nepalis (and no doubt, people in general) make in their efforts to achieve health and wellbeing.

In showing how a bottom-up ethnographic approach that takes seriously the non-biomedical aspects of Nepali immigrants to Norway's food choices offers insights into perceptions of health and wellbeing beyond the limiting lens of biomedicine, this chapter has helped lay the ground for what now follows – a focus on ante- and postnatal dietary habits and practices.

Chapter 5 – Expectations of the Individual: Norwegian Public Health Attitudes towards Dietary Habits and Practices during Pregnancy and after Birth

*“The best way to get the vitamins and minerals you and your child need is through food.”*²⁹

(Matportalen 2015a)

“In order that the child in your abdomen grows and develops, you require more food than usual. For example, you require more vitamins and minerals, and you get them when you eat healthy and varied. You need only supplement folate and vitamin D”.^{30 31}

(Helsedirektorat 2009: 18)

*“A generally good diet with wholegrain bread and cereal products, vegetables and fruit every day gives you all the nutrients you need, also when you are breastfeeding.”*³²

(Helsedirektorat 2011a: 29)

*“Supplements cannot replace the diversity of things that a healthy and varied diet gives.”*³³

(Helsedirektorat 2009: 30; Matportalen 2015a)

Particular dietary recommendations and proscriptions during pregnancy and postnatally pertain throughout the world. They can and do differ markedly, according to cultural practices of a given group. Biomedical and nutrition-based logic underpins much of the advice given in the developed world, but also increasingly elsewhere due to the ever-widening reach of biomedical practices, not least through their intimate association with international development strategies. As we have already seen in the preceding two chapters, biomedical evaluations of diet and

²⁹ Translated from the original Norwegian: “*Den beste måten å få i deg de vitaminene og mineralene du or barnet ditt trenger, er gjennom maten*” (Matportalen 2015a).

³⁰ Vitamin D, either as alone or in the form of a type of fish oil, ‘Tran’ in Norwegian, is taken by many people in Norway, native Norwegians as well as immigrants. This is done to offset potential Vitamin D deficiency, which is a consequence of the limited amount of sunlight exposure consequent on living for any length of time in the country.

³¹ Translated from the original Norwegian: “*For at barnet i magen din skal vokse og utvikle seg, behøver du mer mat enn ellers. Du behøver for eksempel mer vitaminer og mineraler, og dette får du i deg når du spiser sunt og variert. Du trenger kun tilskudd av folat og vitamin D*”.

³² Translated from the Norwegian: “*Et alminnelig godt kosthold med grove brød- og korn-varer, grønnsaker og frukt hver dag, gir deg alle de næringsstoffene du trenger, også når du ammer*”.

³³ In Norwegian: “*kosstilskudd kan ikke erstatte det mangfoldet av stoffer som et sunt og variert kosthold gir*” (Matportalen 2015a); also appears in the Helsedirektorat booklet (2009: 30).

health are used by both Norwegian health authorities (Chapter 3) and the Nepalis I worked with themselves (Chapter 4). Among the Norwegian authorities, the hegemonic application of biomedical logics has enabled a reductive and instrumentalising reading of South Asian immigrants' dietary habits and practices. However, as shown in the previous chapter my Nepali respondents demonstrated a more subtle and fluid view of foodways, notions of health and wellbeing that incorporated yet also reached beyond the biomedical. Together, Chapters 3 and 4 offer useful foundations upon which we can now focus more specifically on ante- and postnatal foodways. Here the dominance of biomedical accounts of food will be shown to circumscribe Norwegian public health authorities' expectations of pregnant women living there, as well as helping to define certain notions of the individual. In the coming chapter, however, through discussion of the maternity-related foodways of the Nepalis I encountered, a significant rejoinder to the Norwegian public health approach emerges.

Throughout the world a discourse of nutrition has become increasingly present within food relations to health, 'medicine as food' as it has been described (Chen 2009; Pollan 2008). Nonetheless, it is worth keeping in mind that both pregnancy and the postnatal period constitute rare instances when this more recent, biomedically-informed reconfiguration of how we might relate to what we eat founders. Instead, for pregnant and nursing mothers, food can often be used in preference to specific medicines, 'food as medicine' in other words. Due to biomedicine's extremely cautious approach to prescribing *any* medicines to pregnant or breastfeeding women because of concerns about possible harm to the developing foetus and then infant, a way is left open for diet to offer remedy. Thus, rather than anti-emetic tablets, foods containing ginger might be advised for 'morning sickness', and consuming peppermint recommended to counter indigestion or trapped wind common during the later stages of pregnancy as well as postnatally. As the quotes from Norwegian state guidelines above show, advice for pregnant women in Norway is explicit in recommending food, rather than any additional medical substances, as the basis for maintaining adequate maternal health during both the antenatal and postnatal periods.

Could it be, however, that such dietary remedies have – especially where western scientific techniques have identified an 'active' ingredient – passed through the filter of 'nutritionism', and are now perceived, by those promoting foods as non-medical sources of symptomatic relief and/or general health-improvement, more as medicine in the form of food? As Chapters 1 and 3 make clear, biomedicine is the overwhelmingly dominant medical system in Norway, and accounts of foodstuffs there – in state-endorsed guidance, the media and commercial food production – are now readily framed according to the language of nutrition, itself predicated according to biomedical epistemology. Reading the Norwegian state-endorsed dietary guidance

and research described below, I was struck by how ‘functional’ the food appeared to be, in service to the health of (in this case) the woman and unborn child: food had effectively become medicine. Yet, as I argue in this thesis, the narrowly medicalised representation of diet which is predominant within the Norwegian public health literature fails to capture the range and complexity of my Nepali respondents’ ways of thinking about food – both with regard to general health as well as more specifically in relation to maternity. As we have already seen in the previous chapter, the Nepalis I worked with had other ways of evaluating what they ate: the significance of taste, satiety, pleasure and commensality were all identifiable within their combined responses. However, this multi-layered appreciation and understanding is easily effaced where food is reduced to its value (or not) to the biomedical human body.

This chapter focuses on attitudes to ante- and postnatal foodways in Norway, as presented through official state guidance as well as some recent public health research. What one finds is the existence of a Norwegian state and public health research approach bound tightly to a biomedical account of food, which focuses heavily on the antenatal period, is directed markedly towards the health of the child and assumes an individualised notion of maternal responsibility for health. Furthermore, there is a distinct tendency towards presenting a biomedically-appropriate, Norwegian-style diet as both ‘healthy’ and ‘normal’, therefore the act of an individual following it (or not) brings in a moral dimension. Consequently, links between the model of ‘food as nutrition’, individualisation and a morally-infused normativity are discernible within the official Norwegian ante- and postnatal literature. These revolve around a particular conception of the responsible, selfless, nurturing individual mother in whose hands the health and wellbeing of their baby lies – the (biomedically-defined) appropriateness of the mother’s own diet a key factor in influencing this. In the process, the sensory, social and other significances of food as food are somewhat lost. And yet these additional significances were clearly evident in my discussions with Nepalis, as will be seen in the coming chapter.

The emphasis in Norway on individualisation – public health bodies and practitioners locating responsibility for wellbeing almost entirely within the individual concerned – is most likely unremarkable to readers raised in so-called developed countries, where biomedical accounts of health tend also to be hegemonic. It can lead to such positions being taken for granted, considered normative among those living within those countries. Moreover, assumptions seem to exist that by providing better information and education to people – published guidance and regular meetings with health practitioners, just two examples – they, as individuals, will

improve their self-care.³⁴ Though, as the next chapter shows, the Nepalis I encountered did appear to subscribe to this Norwegian approach in certain instances, I became aware of a more collective sense of responsibility within their ante- and, especially, postnatal foodways. To appreciate more fully the ways in which these Nepalis' views and practices diverged from the generally atomised, biomedical view of accountability for health dominant within Norwegian research and guidance, we therefore need to explore what was presented as the norm in Norway – the substance of this chapter.

Ante- and postnatal health services in Norway

The state health and welfare systems in Norway cater favourably to all women who are pregnant. Generous maternity benefit and leave entitlements are made available,³⁵ and prior to this comprehensive antenatal services are offered free-of-charge. Pregnant women are eligible to attend pregnancy check-ups either at their general practitioner, one of the *helsestasjoner* (Nor: public health centres) or a combination of the two. *Helsestasjoner* provide services including vaccinations, health checks and health information for children and young people up to the age of twenty, as well as their parents/guardians, and in connection with pregnancy employ midwives to provide antenatal services (IMDi 2012: 64, 67). Oslo Kommune (municipality) is divided up into fifteen *bydel* (Nor: districts), each of which have at least one *helsestasjon*, where pregnant women can receive regular check-ups as well as advice on a variety of issues.³⁶ In addition, between the seventeenth and nineteenth weeks of pregnancy, women are offered a free ultrasound scan at the local maternity department (IMDi 2102: 64).

There is a standard programme of maternal care recommended by the Directorate of Health (Helsedirektorat). The first prenatal check-up should take place between weeks 8-12 with either the patient's GP or a *helsestasjon* midwife. An ultrasound scan is undertaken between weeks 17

³⁴ I should make it clear that this is not a phenomenon exclusive to developed nations or to antenatal and postnatal guidance. The anthropologist, Staples, for example, has identified the emergence of a similar discourse of individualisation and “valorisation of personal responsibility for self-care” among the treatment of disabled people in Hyderabad, South India (2012: 557).

³⁵ NAV, *Norsk Arbeids- og Velferdsforvaltninga*, (Nor: the Norwegian Welfare and Labour Administration), handles maternity benefits (NAV 2013).

³⁶ The website, common to all the *helsestasjoner* in the Oslo municipality, states that *helsestasjoner* offer: “guidance on issues related to life, pregnancy, birth, breastfeeding and prepare you both to be parents. The midwife can talk about concerns related to pregnancy, childbirth, breastfeeding, postnatal care, problems in the relationship, mental health or other topics you might be concerned about.” (Oslo Kommune 2015)

and 19, and then further consultations during pregnancy are recommended in weeks: 24, 28, 32, 36, 38, 40 and 41 (Helsenorge 2014a).

As described in official sources, childbirth “usually” happens either at a hospital or maternity clinic (that the woman has been referred to), and “as a rule” discharge of mother and child from hospital/clinic takes place two to four days afterwards (IMDi 2012: 64). As already stated, no charges are made for this. It is worth noting that in the UK, for example, another developed country where biomedicine dominates health care, new mothers are usually discharged from hospital no more than a day after delivery, and some within a matter of hours (for example, see OUH 2016). This points to the potential variation (as well as potential arbitrariness) of a system presented as so universal and scientifically obvious.

Following birth and leaving the hospital, it is recommended that the new mother and child are visited by a midwife within three days, and by a district nurse (based at the *helsestasjon*) seven to ten days after the birth (Helsenorge 2016a). Thereafter, there is an established programme of regular check-ups usually based at the nearest *helsestasjon*: every month for the first six months and then every other month up until the child is fifteen months old. *Helsestasjoner* fulfil a statutory obligation to provide free health promotion and disease prevention services to all children from birth to five years of age (Oslo Kommune 2014). Within this, themes addressed by the Oslo *helsestasjoner* include sleep, breast- and bottle-feeding, nutrition, motor-, language- and psychosocial development, accident prevention, parent-child interaction as well as guidance and support regarding a child’s mental health (ibid).

Written guidance and information on pregnancy and the postnatal period is published by the Helsedirektorat and made freely and readily available both as pamphlets at *helsestasjoner* and in GP surgeries, as well as online. Advice is also disseminated in the form of two books: one relating to pregnancy, *Svangerskaps boken* (Nor: The Pregnancy book), the other focused on the twelve months following birth, *Spedbarns boken* (Nor: The Infant book). Both are again free of charge, the former given out by GPs and *helsestasjoner*, the latter to the new mother in the hospital or clinic where she has given birth. These texts will be discussed in more detail below, as they demonstrate clearly the ways in which the official Norwegian guidance promotes a biomedical account of food and is weighted predominantly towards the antenatal period and wellbeing of the child – in contrast to the alternative emphases among my Nepali respondents, which will be discussed in the chapter that then follows.

Official Norwegian antenatal dietary information and advice

As mentioned in earlier chapters, the Helsedirektorat offers and monitors public health advice and acts to ensure that policies are implemented in the healthcare sector. In relation to diet in pregnancy, the directorate publishes its own guidelines on eating habits during pregnancy, as part of the booklet, *Liv sunt i svangerskap* (Nor: Live healthily during pregnancy) (Helsedirektorat 2009), and is associated with other health and nutrition information sources readily accessible in the public domain. One of these additional information sources is Matportalen, already introduced in Chapter 1. Another is Helsenorge, a web-based guide to public health services within the Norwegian healthcare system and under the executive editorship of the Helsedirektorat (Helsenorge 2016b).

Allowing for differences in order of information and presentation (most notably, more numerous and colourful graphics in the Helsedirektorat booklet as compared with the webpages), the content of dietary advice for pregnant women given in each of these information sources is very similar, and in some places almost identical. This is unsurprising since both Helsenorge and Matportalen are explicit about using information from the Helsedirektorat. Moreover, there is cross-referencing between the sources, readers' given links or web addresses to the other sites. In each case, the advice regarding diet in pregnancy can be seen to address three main areas: what should be eaten, what should not be eaten, and vitamins, minerals and supplements.

In terms of what to eat, the recommendations that are most prominently reiterated by each of the information sources is to: eat the "five a day", i.e. five portions of vegetables and fruit; eat wholegrain and bread products; eat fish two to three times a week; choose lean meats and dairy products; choose preferably wholegrain products; choose soft margarine or vegetable oil (rather than butter); and that water is recommended as the best drink when thirsty.

Similarly, what not to eat focuses on foods that might contain listeria or toxoplasma, both potentially very harmful to a developing foetus, a fact which is stated clearly in all of the sources. Accordingly, certain fish (raw, very large shellfish and fish liver products), meat (raw, whale, seal – these latter two, evidence of certain Norway-specific elements within the guidance) and dairy products (unpasteurised and 'blue' cheeses) readers are told to avoid. Alcohol and tobacco are also declared as substances to abstain from. Attention to kitchen hygiene is mentioned as well, emphasising in particular the need to wash thoroughly fruit and vegetables, and implements used to prepare raw meat.

With regard to vitamins, minerals and *kosttilskudd* (Nor: supplements), only folic acid and vitamin D are judged to be necessary to take as supplements in addition to eating “a healthy and varied diet” (Helsedirektorat 2009: 30). Iron and calcium are also highlighted as important, but dietary sources are emphasised instead: liver, green vegetables and meat some of the suggestions for iron; milk, yoghurt, cheese and nuts for calcium. Supplements, therefore, are presented as unnecessary in the context of the recommended “healthy and varied diet”, and a cautious note is sounded about possible risks of ingesting too much of some vitamins or minerals that in excess could have harmful effects (ibid). In fact, as shown in the opening quotes to this chapter, all the guidelines are explicit about food being the best source of nutrients.

Naturlegemidler (Nor: Natural medicines) are treated with similar caution, due to “a lack of efficacy and safety [information]” for most natural medicines and supplements (Helsedirektorat 2009: 30; Helsenorge 2014c). Consequently, the advice given is that pregnant women should not use them. This position, and its justification, situates all the recommendations firmly within a biomedical paradigm – unsurprising given its dominant status in Norway.

The subject of weight gain and how much a pregnant women should eat, including trimester-specific guidance regarding between-meal snacks, also features in every information source. Low-fat meat and dairy foods are repeatedly recommended, and frequent mention is made that although they require a little more food, pregnant women need not eat much more, a “typical weight gain [of] between 11 and 16 kilograms” specified (Helsenorge 2014b). All told, although slimming is explicitly counselled against, the texts convey concern over significant weight-gain during pregnancy.

In addition to these sources there is the already-mentioned *Svangerskaps boken*, given free to all pregnant women, following their first antenatal appointment either with a GP or at a *helsestasjon* (Sandvik 2014a). Published in association with the website, *babyverden.no*, and regularly updated, it acts as perhaps one of the most readily accessible (in that each woman is given a personal copy to keep) sources of information about pregnancy. Given over mainly to a week-by-week account and explanation of the baby’s development, there is a comparatively short entry (four pages) relating to diet: “*Kosthold, fysisk aktivitet og helse*” (Nor: Diet, physical activity and health). The diet related part of the chapter features seven sub-headings – ‘Eating for two’, ‘Eat varied and vitamin rich!’, ‘Get enough iron in you!’, ‘Special care to take when you are pregnant’, ‘The Food Safety Organisation’s recommendations’, ‘Toxoplasmosis’

and ‘Listeria’³⁷ – which essentially reiterate what is laid out more fully in the Helsedirektorat, Helsenorge and Matportalen guidance. Moreover, while not directly allied with any of these institutions, *Svangerskaps boken* cross-checks some of its content with Helsedirektorat guidance and suggests readers consult Matportalen webpages for detailed information about what foodstuffs to avoid during pregnancy.

I was unable to find specific references to the sources that these Norwegian recommendations are drawn from. However, the similarity of the ‘five a day’ advice, for example, to health promotion efforts in other countries such as the UK (NHS 2015),³⁸ suggests a common source. And in the case of the ‘five a day’ guidance, this would appear to be the World Health Organisation (WHO) and Food and Agriculture Organisation of the United Nations (FAO). Following a joint report (WHO/FAO 2003),³⁹ in 2003 these organisations launched the promotion of an initiative to encourage “fruit and vegetables for health worldwide” (WHO 2016a). A key recommendation was the consumption of “a minimum of 400g of fruit and vegetables per day (excluding potatoes and other starchy tubers)”, with the aim of preventing chronic disease including obesity, cancer, diabetes and heart disease, as well as reducing the incidence and alleviating the effects of “several micronutrient deficiencies, especially in less developed countries” (ibid). Norway’s Helsedirektorat clearly seems to have adopted this recommendation – “Eat at least five portions of vegetables, fruit and berries every day”⁴⁰ – albeit modifying it upwards slightly, counselling that each portion is the equivalent of 100g, a total of 500g per day (Helsedirektorat 2016). This may well reflect more recent debates suggesting that ‘5 a day’ as defined by the WHO/FAO (i.e. at least 400g per day) may not be sufficient to achieve the intended health benefits (for example, see: NHS 2014; Oyebode et al. 2014).

³⁷ Translated from Norwegian: ‘Å spise for to’, ‘Spis variert og vitaminrik!’, ‘Få nok jern i deg!’, ‘Spesielle hensyn å ta når du er gravid’, ‘Mattilsynets anbefalinger’, ‘Toxoplasrose’ and ‘Listeriose’ (Sandvik 2014a).

³⁸ The NHS webpage specifically acknowledges the WHO as the source of advice to consume “a minimum of 400g of fruit and vegetables a day to lower the risk of serious health problems, such as heart disease, stroke, type 2 diabetes and obesity” (NHS 2015).

³⁹ The Report was formally launched in on 23 April 2003, in Rome, by the then Director Generals of both organisations. In the case of the WHO, this was the Norwegian, Dr Gro Harlem Brundtland (WHO 2016b), who had previously served as Prime Minister in Norway (WHO 2016c).

⁴⁰ Translated from the Norwegian: “Spis minst fem porsjoner grønnsaker, frukt og bær hverdag” (Helsedirektorat 2016)

All of the various Norwegian guidelines I reviewed implicitly assume a particular kind of ‘normal’ diet. This, it transpires, is an identifiably Norwegian way of eating and combining foods: three main meals a day; usually bread for breakfast and at lunch, and also as a snack; fish a regular part of the diet; the collapsing of fruit and vegetables into one category, fruit also readily consumed as a juice; regular drinking of milk and eating of cheese; the privileging of lower-fat alternatives (e.g. margarine) because they are ‘more healthy’. In terms of the trimester-specific guidance regarding between-meals snacks, for example, all three guidelines give the same recommendations: 1-3 months, one piece of fruit, e.g. an apple; 4-6 months, one between-meal snack, e.g. sandwich plus one piece of fruit, e.g. an orange; 7-9 months, two between-meal snacks, e.g. oatmeal, and one piece of fruit, e.g. a pear. (See, for example, Helsedirektorat 2009: 20). As discussed in Chapter 3, this reflects a typically Norwegian pattern and style of eating (see Kjærnes 2001; Holm 2013), an emphasis that is retained in the post-natal foodways advice as well (see below).

There have been apparent attempts to tailor dietary advice towards non-Norwegian tastes, a notable example being a state-funded publication on healthy eating for diabetics aimed specifically at Norway’s relatively large Pakistani population (SEF 2002). It speaks directly to the anxieties already discussed that abound within Norwegian public health discourse on the dietary habits and risk status of South Asians living in Norway more generally (see Chapters 1, 3 and 4). The colourful brochure, written in Norwegian and Urdu, offers a couple of recipes for healthier ‘Asian-style’ dishes, such as a “chickpea salad” (ibid: 8) and “salmon tandoori” (ibid: 15); it also suggests certain substitutions – for example, eating fruit instead of samosas, or using semi-skimmed milk instead of whole milk in tea (ibid: 6). Further it recommends a breakfast of “wholemeal bread with a little yellow cheese, cucumber and tomato” accompanied by “a glass of semi-skimmed milk” (ibid). Yet, taken together with graphics that include a supermarket trolley filled with typical Norwegian products (tinned mackerel, a loaf of wholemeal bread, reduced fat yellow cheese, skimmed milk), it in fact urges the reader towards a more conventionally Norwegian-style diet, one that is additionally appropriate for people with diabetes.

I could find no equivalent attempts to take into account non-Norwegian foodways within dietary guidance for pregnant or postnatal women in Norway. Given that much of this guidance was published or updated since the SEF brochure (itself less diversifying than it first seems), it might well be that it is not deemed necessary. Moreover, I would speculate that any particular foodways issues, specific to a given woman, might be assumed by state bodies such as the Helsedirektorat to be addressed more in face-to-face meetings with health practitioners (either the GP or *helsestasjon* personnel).

Taken together, the official antenatal guidance's presentation of what the 'normal' diet for a pregnant woman in Norway might comprise and the food-related recommendations made to diabetic Pakistanis living there, point to a specific and dominant characterisation of what they (the public health authorities) consider to be 'normal'. This characterisation is, in turn, built on a very culturally-specific model, namely that of the identifiably Norwegian way of eating that has been outlined above. This has echoes of Foucault's (1991b) concept of 'normalisation'. Although initially identified as operating within military and religious institutions – where it emerged via processes of comparison, hierarchy production, differentiation, homogenisation and exclusion – Foucault also saw it at play within education and (of relevance here) health services, where it enabled “general norms of health” to be defined (ibid: 183 – 84). Moreover, by imposing homogeneity, normalisation processes also make it possible to individualise, through the measurement of “gaps” between people and offering means to compare them (ibid: 184). Thus in apparent systems of equality, he argued, which Norway would appear to embody with its conscious attitudes to gender equality for example (see Chapter 2), “the power of the norm” can function well – where homogeneity is the rule, the norm acts as an imperative and measure for defining “all the shading of individual differences” (ibid). In the case of my study, the standard invoked by the Norwegian health authorities' promotion of a specific form of dietary 'normality' becomes a means through which individual subjects can effectively be measured by how much they adhere (or not) to the recommendations. Sanction for failing to eat 'normally' may subsequently come during contacts with health personnel, yet also, as Middelthon (2009) and Coveney (2006) make clear, from self and society more generally, through a moral encoding of food as 'healthy' or 'unhealthy'.

In pregnancy (as well as postnatally) the pressure exerted by the norm is indubitably present, evident in the specific dietary guidance produced. And as well as a particular (Norwegianly-'normal') way of eating being prescribed, imbued within it are also notions of personal responsibility and self-regulation. Therein we see Foucault's (1991a) concept of 'governmentality' in operation – the family (and individuals within it) reconfigured as elements within a surveilled population, which, as Coveney (2006) explains is thus subject to and instrumentalised in service to a particular nutrition discourse. Yet this rhetoric of social sanction regarding individual responsibility is also present in Middelthon's (2009) exploration of the morality surrounding food choices in contemporary Norway. What my review of the official biomedical antenatal dietary advice shows is that the extent to which an individual mother-to-be in Norway does or does not follow it can be used as a means of judging how effectively she is acting to ensure the health of her coming baby. However, as will be seen, the Nepalis I worked with although welcoming a considerable proportion of the biomedical input available, also drew on alternative understandings of what foodstuffs were necessary to bring about a healthy child.

In doing so, they highlight particular contingencies active when considering maternity-related eating habits and practices, such as Norwegian vs. Nepali norms, public health structures and information vs. family and friends, and recommendations (official and private) vs. personal agency.

Official Norwegian postnatal dietary information and advice

From the official health bodies, Norwegian guidance about what women should eat following birth is given mainly in publications focused more either on breastfeeding (Helsedirektorat 2011a; Matportalen 2016b) or on the newly born child (Sandvik 2014b). In the Helsedirektorat's brochure 'How you breastfeed your child – some advice for the first time',⁴¹ approximately three of the forty-two pages address the topic of diet. Matportalen, on the other hand, offers a (short) online section specifically on the subject of *Ammende* (Nor: breastfeeding) (Matportalen 2016b). Within the *Spedbarns boken* (the postnatal equivalent to *Svangerskaps boken*), again done in cooperation with *babyverden.no* and this time given to each new mother at the place of birth (Sandvik 2014b), there is one chapter given over to maternal diet, written by clinical nutrition physiologist based at the Helsedirektorat (Hay 2014).

As with the antenatal advice, there is an emphasis once again on the importance of a “*fullverdig og balansert kosthold*” (Nor: full-value and balanced diet) , with essentially the same examples as in the pregnancy-directed guidance, albeit presented in rather less detail (Hay 2014; Helsedirektorat 2011a; Matportalen 2016b). Again links are provided to texts offering general dietary advice. That said, the *Spedbarns boken* chapter goes into quite some depth about the vitamins, minerals and trace elements that “should also be increased somewhat during pregnancy and breastfeeding” (Hay 2014: 32). The different groups are discussed and indications given as to the extent to which the maternal diet influences the relative quantities of the vitamins, minerals and trace elements resulting in the breast milk. Foods considered to be good ‘sources’ of these specific nutrient elements are consequently identified, especially those more dependent on the mother's own intake of them. In fact the word ‘source’ (*kilde*, in Norwegian) and references to nutrients being “*finnes i*” (Nor: found in) features repeatedly throughout the chapter, as well as in all the other official dietary guidance. This again gives the impression of food principally as a vehicle for the transmission of more or less valuable nutrients, a perception more of ‘medicine as food’.

⁴¹ Translation from Norwegian: “*Hvordan du ammer ditt barn – noen råd den første tiden*” (Helsedirektorat 2011a).

There is an acknowledgment that slightly more energy is required in order to maintain the health of the mother to enable her to breastfeed, moreover that most women experience an increase in appetite (Hay 2014: 32). Recommendations are given for how this extra demand can be met, the Helsedirektorat guidance offering:

“You need a little more food than before to supply the nutrients excreted in breast milk. For example, two glasses of skimmed milk plus 2 slices wholemeal bread with toppings cover the extra demand. If you eat an orange or drink a glass of orange juice with the bread, the milk will contain enough vitamin C to meet the child's needs while the iron in bread is absorbed better. Your breasts will always create high-quality milk for they have your whole body reserve. The healthy diet benefits primarily yourself.” (Helsedirektorat 2011a: 29)⁴²

Again, the typically Norwegian kind of diet that these suggested foods represent, as well as their rather ‘healthy’ nature (biomedically-speaking) and the stress on the individual are all evident. The *Spedbarns boken*, meanwhile, is clear on the matter of what food is required: “The increased energy need should be met with nutritious fare”.⁴³ In fact the supplementing of any additional energy needs with sugary and fatty foods is explicitly discouraged. Separately titled sub-sections are given over in all the guidance to this. From Helsedirektorat, advice comes under the rubric “... But not sweet support” (Helsedirektorat 2011a: 30), while in the Matportalen and *Spedbarns boken* entries it is found within a larger section “What should breastfeeders be careful with?”, under the heading “Sweets and Fats” (Hay 2014: 34; Matportalen 2016b).⁴⁴ The guidance is once more posited in terms of nutritional value as well as calories in this case. For example: “Foods that contain a lot of sugar and fat (such as chocolate, ice cream, soda, cakes, snacks) provide little nutrients, but a lot of energy (calories). Such foods should therefore not be a major component of the diet.”⁴⁵ A little added sugar in the diet is

⁴² Translated from the Norwegian: “*Du trenger litt mer mat enn før for å tilføre de næringsstoffene som skilles ut i morsmelken. For eksempel vil 2 glass skummet melk pluss 2 skiver grovt brød med pålegg dekke det ekstra behovet. Dersom du spiser en appelsin eller drikker et glass appelsinjuice til brødmaten, vil melken din inneholde nok vitamin C til å dekke barnets behov, samtidig som jernet i brødet opptas bedre. Brystene dine vil alltid lage fullverdig melk for de har hele kroppen din som reserve. Det sunne kostholdet gagnar først og fremst deg selv.*” (Helsedirektorat 2011a: 29).

⁴³ Translation from Norwegian: “*Det økte energibehovet bør dekkes ved næringsrik kost.*” (Hay 2014: 32).

⁴⁴ Translated from the Norwegian: “*... Men ikke søtt støtt*” (Helsedirektorat 2011a: 30), and “*Hva bør ammende være forsiktig med?*” and “*Søtt og Fett*” (Hay 2014: 34; Matportalen 2016b).

⁴⁵ Translation from the Norwegian: “*Matvarer som inneholder mye sukker og fett (for eksempel sjokolade, is, brus, kaker, snacks) gir lite næringsstoffer, men mye energi (kalorier). Slike matvarer bør derfor ikke utgjøre en stor del av kostholdet.*” (Hay 2014: 34; Helsedirektorat 2011a: 30)

considered “ok, in an otherwise varied diet” but cravings for sweet things are best met by “fresh fruit and fresh berries” (Helsedirektorat 2011a: 30).⁴⁶ Matportalen and *Spedbarns boken*, meanwhile, encourage the use of dried fruits and nuts as “*sunt snacks*” (Nor: healthy snacks) (Hay 2014: 33; Matportalen 2016b). One intriguing indication of what might have been previous advice or even ‘folk’ beliefs regarding postnatal diet relates to chocolate, which receives a special mention in all three sources. Readers are reassured that “contrary to its reputation”, chocolate can be eaten in moderation without causing colic, diarrhoea or constipation in the infant (Hay 2014: 34; Helsedirektorat 2011a: 30; Matportalen 2016b).

The Infant book does have a special subsection devoted to ‘*Fett*’ (Nor: Fat), the exclusive focus of which is on omega-3 and omega-6 fatty acids because they are “important for the child’s growth and development, especially for the brain and nervous system” (Hay 2014: 33).⁴⁷ Again, there follows information about foods that are *gode kilder* (Nor: good sources) for these specific nutrients.

Regarding weight loss, the advice given is that most women usually experience a gradual loss of their pregnancy-related excess weight following birth “if they eat correctly and exercise” (Hay 2014: 32; Matportalen 2016b).⁴⁸ There are warnings, however, not to lose weight too quickly, and deliberate dieting is not recommended on account that “pollutants are released from the fat in the body and [then] excreted in the breast milk” (ibid). Similarly, women are told they should not take certain slimming aids (notably conjugated linoleic acids (CLA), a preparation associated with fat loss and muscle growth) (Hay 2014: 35; Matportalen 2013b, 2016b).

Consumption of tea, coffee and other caffeine-containing drinks by a new mother, should, the guidelines assert, continue to be limited during the breastfeeding period. This advice is essentially the same as provided in antenatal guidelines, albeit now for different reasons. Where in pregnancy the risk related to miscarriage, following birth it refers to passage of caffeine to the baby via the breast milk, potentially causing them to become irritable and disturbing their sleep. Coffee and black tea are also singled out as potentially disrupting the absorption of iron, so

⁴⁶ Translated from Norwegian: “*ok, i et ellers variert kosthold*”, “*frisk frukt og frisk bær*” (Helsedirektorat 2011a: 30)

⁴⁷ Translated from the Norwegian: “*viktige for barnets vekst og utvikling, spesielt for hjernen og nervesystemet*” (Hay 2014: 33).

⁴⁸ Translated from the Norwegian: “*hvis de spiser riktig og mosjonerer*”. There is another verb in Norwegian, *å trene*, that is used to refer to more organised and regular exercise, e.g. going to the gym. Use here of the verb, *mosjonerer* (infinitive: *å mosjonere*), I interpret as intentional, used to suggest less formal and likely gentler exercise.

would-be drinkers advised to consume them away from mealtimes or substitute for an alternative, for example such as fruit tea. Reference is also made to *amme-tee* (Nor: breastfeeding tea), a widely available herbal tea blend, whose key ingredients (as noted by the producers) are fenugreek, anise and fennel seeds.⁴⁹ A high intake of this “can be adverse” for the infant, so only one to two cups a day at most advised (Hay 2014: 34; Helsedirektorat 2011a: 31; Matportalen 2016b). The comparatively ‘exotic’ ingredients in *amme-tee*, not least the spices highlighted by the producers, find, as will be seen in the coming chapter, an interesting parallel in the practice of the Nepali mothers I spoke to who almost universally spoke of consuming soups and broths rich in thyme seed (*jwano*, in Nepali), as it was widely held to improve breastmilk production.

Alcohol, nicotine and any narcotics will cross over into the breast milk, the official guidance explains. Nevertheless, the way the information is given indicates that there is an acceptance that the first two substances will be consumed by at least some women in the postnatal period – the emphasis then placed on how to minimise the effects on the newborn. I had asked all the Nepalis I interviewed whether they drank or smoked. Among the women, only one admitted smoking when she was in her early twenties but not since becoming a mother; several, however, reported drinking alcohol occasionally (and at Indira’s gathering, for example, nearly half the women present drank a modestly-proportioned glass of wine) but none admitted to doing so while pregnant or in the initial months following childbirth.

The chapter on maternal diet in *Spedbarns boken* ends with a summary paragraph that attempts to unite maternal choice with what was written on the preceding pages: “If you follow your appetite and put it together with the diet described above, you will easily be able to meet both your needs and the child while breastfeeding” (Hay 2014: 35).⁵⁰ At the same time it seeks to reassure mothers whose intake of nutrients is limited that they too can produce milk of enough quality and quantity to ensure the health of their child. In fact the author also takes a chance to advance what she advises to beyond the postnatal period, concluding by telling readers: “Pregnancy and breast-feeding are fine opportunities to incorporate healthy eating habits in the family. This will also benefit the child later” (ibid). Mindful of Hay’s background as a nutritionist, this points to a potentially broader agenda – improving the general diet of those residing in Norway. Hence it is again possible to perceive elements of Coveney’s (2006) thesis

⁴⁹ Examples available in local healthfood shops included ‘Weleda Nursing Tea’, ‘Neuner’s Nursing Tea’ and ‘Yogi Woman’s Nursing Support Tea’.

⁵⁰ Translated from Norwegian: “Hvis du følger din appetitt og sette sammen kostholdet som beskrevet ovenfor, vil du lett kunne møte både dine behov og ditt barn gjennom morsmelk.” (Hay 2014: 35)

regarding certain ‘governmentality’-inspired aims of the nutrition discourse, to produce and maintain a healthy society. Moreover, it also draws on the notions of self-regulation and self-governance within diet that Coveney advances, and which are discussed above in relation to official antenatal advice. Here, however, there appears to be not only an attempt to engender a strong sense of self-responsibility among mothers but also to couple it to a long-termism. That is, that the current food choices of each mother will impact on their child(ren)’s current *and* future health. The figure of the mother thus produced here is that of an individual who should attend to their own eating habits and practices in a specific way *now* because through these they are ultimately responsible for ensuring the physical health and wellbeing of their offspring *henceforth*; the mother’s own health and wellbeing, meanwhile, receives relatively scant attention.

Overall, the postnatal dietary guidance is considerably shorter in length, compared to that available to pregnant women. Moreover, its major focus is on breastfeeding. Again the language used is biomedical and relates to food as a potential source (or not) of nutrition, a version of ‘medicine as food’. Furthermore, the overriding emphasis in these texts concerns the effect on the infant of what the mother eats. While this is understandable if one takes into account the relative vulnerability and underdevelopment of the child’s body, digestive and immune systems, it nevertheless places their needs firmly above those of the mother – for the duration of the breastfeeding period, yet also on the pages of the various sources of health service guidance. The official health services’ account of a maternal postnatal diet is therefore presented as mainly a question of adequate nutrition in the service of the child. And this is where my own ethnographic findings, detailed in the coming chapter, constitute such a significant riposte. For, as will be seen, among the Nepalis I worked with it was very much the mother’s wellbeing and the web of relations that surrounded her that mattered in the aftermath of birth. These differing positions, of the official Norwegian guidance and my Nepali respondents own postnatal foodways and practices – and the alternative figures of motherhood that they act to produce – are something I will return to in the conclusion (Chapter 7).

At present, dietary guidance published and disseminated by the Helsedirektorat for pregnant women and those who have recently given birth refer to food in terms almost wholly from within the biomedical nutrition paradigm. An exception could be the assertion that “[F]ood should taste good”, (Helsenorge 2014b) but this seems slight, especially when set alongside the understandable but nonetheless firm advice against taking ‘natural medicines’ because they cannot be assessed according to (implicitly) biomedical standards. Consequently, contested or otherwise, these nutritional recommendations assume a particular kind of authority, state and

biomedical, and carry certain expectations of those who read them, state subjects, that they will be adhered to.

These are, nonetheless, only recommendations or guidelines. How closely such distilled dietary information actually relates to that received by women when they come into contact with official antenatal services, and what they make of and do with it, is another matter. Nirmala's intuitive response, discussed in the next chapter, to signs that her baby was not growing as much as expected, is a good example of this. In setting out such high standards, possibly even over-emphasising the importance of, say, how much fruit and vegetables are eaten in a day, it could be that authorities such as the Helsedirektorat expect people will fall short. Nevertheless, by producing their 'counsels of perfection', these institutions aim to get peoples' dietary habits and practices moving 'in the right direction', according to the prevailing biomedical logics that the institutions endorse and base their information on. If this is the case, it challenges the projected idea that all such policy is driven by scientific thinking – further highlighting the contingent nature of biomedical authority.

Crucially, perhaps, it should be noted that most of the written guidance is in Norwegian. Certain parts of the websites offer English translations, but these are usually abbreviated and relatively superficial, and while it was possible to order some leaflets in Hindi or Urdu (not Nepali), or request translators at medical appointments, the vast majority of written guidance in any detail is in Norwegian. While some of the Nepalis I met were fluent in Norwegian, several were not and they relied mainly on English (in which most were competent) in their day-to-day communication with Norwegians and Norwegian services and institutions.⁵¹ The relevance of the written information to those women I worked with was therefore questionable. Nonetheless, elements of its contents would to some degree or other have been communicated during encounters with health personnel. And, as will now be discussed, findings from a recent study seem to show that such antenatal information and advice could be effective if delivered in a personalised way.

⁵¹ Bearing in mind that my respondents were middle class, the vast majority highly-educated as well, they were nevertheless better placed to access such information than certain other South Asian immigrants (for example the Pakistanis discussed in Chapter 4), who were even less likely to speak or read English, let alone Norwegian.

**‘Promoting a Healthy Diet in antenatal care: Qualitative studies of barriers to nutrition communication among women of different ethnic backgrounds in the Oslo Area’
(Garnweidner 2013)**

Relatively recent public health doctoral research carried out in Oslo looked specifically at the issue of antenatal eating habits among women there, with a particular focus on immigrants (Garnweidner 2013). Garnweidner, a nutritional scientist, reiterated the concerns, discussed in previous chapters, about the effects of dietary change on the health of people migrating – especially those from Africa and South Asia – to higher income countries, emphasis laid on the increased risks of overweightness and developing diabetes. Her research worked from existing findings suggesting pregnancy and the time after birth as periods when women were more receptive to dietary advice aimed at preventing excessive weight gain and diet-related diseases for themselves and their offspring (Hanson et al. 2011; Thangaratinam et al. 2012), yet that cultural practices and beliefs about food consumption could be at odds with public health guidelines and recommendations. Accordingly, Garnweidner carried out research comprising three sub-studies, the overall aim of which was “to identify possible barriers to nutrition communication relevant for antenatal care, based on the experience of women of different ethnic backgrounds” (Garnweidner 2013:6).

Of particular relevance to this chapter are the findings relating to the second and third sub-studies: “perceptions and experiences with verbal nutrition-related information received in antenatal care [specifically, at the *helsestasjoner*] among women of different ethnic backgrounds with higher risk of diet-related diseases” the focus of the second study, while the third explored “attitudes and motivations for healthy eating among pregnant women of different ethnic backgrounds with higher risk of diet-related diseases” (ibid).

Prior to discussing and interpreting these, though, it is first helpful to delineate Garnweidner’s disciplinary and theoretical stance. While drawing on existing public health work (Kotürck-Runefors (1991), Holmboe-Otteson & Wandel (2012) and Wandel et al. (2008) among others – see Chapters 1 and 4) to discuss processes of adaptation to new dietary patterns following migration, a principal focus of Garnweidner’s was “nutrition communication” and “nutrition literacy” (Garnweidner 2013: 13 – 19). These, she posited as sub-disciplines or concepts of “health communication” and “health literacy” respectively (ibid).

Within public health and health promotion, health communication has come to be recognised as a scientific discipline, which strategically employs communication methods intended to develop “skills” and “confidence” that thus bring about “behaviour change and compliance” in those they are aimed at (Schiavo 2007). Amongst efforts to counter overweightness and dietary-

related diseases, health communication has apparently achieved a prominent role (ibid). Garnweidner suggests that nutrition communication would be a worthy sub-discipline, in the context of her thesis defined as “the study and use of interpersonal communication strategies relevant for the promotion of a healthy diet in antenatal care...[linking] evidence-based communication strategies together with nutritional sciences” (Garnweidner 2013: 13 – 14). Acknowledging the significance of cultural and ethnic differences to effective health communication (as defined within the public health paradigm), the centrality of these factors within nutrition communication is hence asserted (ibid: 15). By combining this position with adoption of the ‘Culture-Sensitive Approach’ (CSA), whereby ‘culture’ is perceived of as a variable that might explain obstacles to health communication and cultural sensitivity a means through which existing health communication strategies are apparently rendered more relevant to their intended recipients through the incorporation of certain cultural factors (Rensnicow et al 1999),⁵² Garnweidner presents nutrition communication as an instrument, capable of affecting dietary change in those to whom it is directed.

A similarly functional perspective was taken with the concept of “health literacy”, which has been used to describe an individual’s capacity to access, understand, appraise and then apply health information in order to make decisions and take actions in relation to illness, risk of it and maintaining health (Sørensen et al. 2012). This has apparently gained increasing currency and profile within health communication and promotion (Garnweidner 2013: 18 –19). Garnweidner again suggests a nutrition-focused sub-division, “nutritional literacy” that would refer specifically to information directed towards dietary decisions, going on to highlight the use of non-written resources, such as pictures, cartoons and videos, as valuable within such work – something also noted by other Norwegian researchers looking into immigrant foodways and health (Kumar & Ayub 2010; Helsedirektorat 2011b).

Despite the straightforwardly instrumentalist readings of health information interactions described above, it should be noted that Garnweidner acknowledged the importance of a culturally relative view if such communication was to be ‘culture-sensitive’, as well as the risk of applying the highly individualised notions of self and health, predominant within Western societies, to people coming from places where alternate medical systems and health beliefs may also exist (Garnweidner 2013: 17 –18). Moreover, she was self-reflexive about her work,

⁵² Cultural sensitivity is defined by Resnicow et al. as: “the extent to which ethnic and cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a target population and relevant historical, environmental and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs” (1999: 11).

conscious that her background as a “nutritional scientist” would have had some influence on her research and seeking to draw on phenomenological perspectives to account for the active role of the researcher in making sense of the experiences of her informants’ (ibid: 23).

Garnweidner’s work is rooted firmly within the public health field,⁵³ and uses qualitative methodology, namely semi-structured interviewing. In sub-studies two and three the data was gathered longitudinally – each participant interviewed twice during pregnancy and once three months after giving birth. In total, seventeen women, pregnant for the first time, were interviewed for sub-study two and sixteen for sub-study three: five ethnic Norwegians, two Norwegian-born to Pakistani parents and ten born elsewhere who had moved to Norway (nine from this group in the third sub-study). No Nepalis featured within this group; rather, of South Asian origin, there was one Sri Lankan and one Pakistani woman, plus the two women born of Pakistani parents.⁵⁴ The study participants ranged in age from 19 to 38. All were overweight, a significant risk factor associated with the development of gestational diabetes, which itself can be harmful to mother and child both during pregnancy but is also linked to health problems – for the women and the children – subsequently (Djelantik et al. 2012; Holmboe-Otteson & Wandel 2012; Jenum et al. 2012; Makgoba et al. 2012).

Results from the second sub-study showed that the women described the nutritional advice they received as part of formal antenatal care as rather non-specific, mainly focusing on food safety rather than weight control; furthermore, that the information came too late in their pregnancy. Garnweidner noted that she (and her co-researchers) perceived a relative lack of awareness about the possible risks to the future health of mother and child that being overweight before and during pregnancy could potentiate. Some differences were suggested in relation to women’s ethnic backgrounds, mainly that information incongruent with a woman’s “original food culture” appeared (to the researchers) to have been met with confusion by the women, contradictory guidance received as challenging (ibid: 37). Nevertheless, the study participants were seemingly open and interested to receive the nutritional information and actively sought it out, especially early on in the pregnancy, moving between various sources. In addition to the formal advice from the health services, the internet and a woman’s network of friends, family and colleagues were all availed of, something the Nepalis I worked with also did, as detailed in

⁵³ The thesis was submitted to the University of Oslo’s Faculty of Medicine, where Garnweidner had already gained a Master’s degree in Food technology and nutrition physiology; for PhD studies, however, she was based with the Department of Health, Nutrition and Management at Oslo and Akershus University College of Applied Sciences (HiOA) (Garnweidner 2013).

⁵⁴ Of the remaining women born outside of Norway, one each came from Albania, Afghanistan, Russia, Thailand and Turkey, and three from Somalia (Garnweidner 2013: 27).

the coming chapter. Towards the end of their pregnancies, several participants had described feeling overwhelmed by the extent of information. More generally it is worth noting that some of the women admitted to difficulty recalling the health-related information they had received, which, as we will see, was a common finding among the Nepali women I spoke with too.

Turning to the third sub-study's results, it was shown that while the women apparently expressed giving extra attention to their eating habits at some point during their pregnancies, pregnancy *per se* was found not necessarily to be a motivation for healthier eating. Three different types of behaviour were discerned and defined among the study group: "healthy changers", who became more conscious of eating healthily during their pregnancy and aimed to maintain such habits afterwards as well; "temporary health forcers", who tried to eat healthily only while they were pregnant; and the so-called "unhealthy vacationers", who regarded pregnancy as an opportunity to take a break from eating healthily (ibid: 38). No patterns could be found in terms of the women's ethnic backgrounds. Some women born outside of Norway asserted a wish to maintain dietary habits from their country of origin and "perceived their pre-pregnancy weight gain as a consequence of moving to a more affluent country"(ibid). Garnweidner's inference here could be read as slightly patronising and judgemental: that the women are somehow unaware or unacknowledging of the (obvious to the researcher) link between their pre-existing dietary habits and overweightness, and that their weight gain is something that they should regard as inherently negative.

The motivations associated with the three different types of nutrition-related behavioural change Garnweidner subsequently characterised in terms of self-autonomy. The 'healthy changers' interest in their own health motivated their healthy eating endeavours, the 'temporary health forcers' located their motivation only to the fact of the pregnancy, and the 'unhealthy vacationers' apparently without any motivation during the pregnancy to eat healthily. Garnweidner adds that those within this last group had a pre-pregnancy history of dieting and stated dissatisfaction with their weight before they became pregnant.

Given her overall aim – to draw on the experiences of women with different ethnic backgrounds and identify potential barriers to the communication of nutrition-related information within antenatal care – it is noteworthy that Garnweidner's thesis ultimately argued that the main factors shaping communication outcomes related to the women themselves, and not to the Norwegian health system (presented, tacitly, as normative in its standards and practices). To challenge potential communication barriers thus entailed considering: "1) the possible influence of individuals' ethnical [*sic.*] and cultural background on food practices, 2) individuals' prior knowledge and capability for understanding the nutrition-related information and 3) individuals'

attitudes toward and motivations for healthy eating” (ibid: 61). In sum, Garnweidner saw her findings as pointing to the need for “an individually tailored communication approach” (ibid). And, within this, efforts that emphasised the recipient’s health literacy and attended to “cultural sensitivity” were deemed important. The emphasis here on ‘individuals’, their background as well as motivation, cannot be missed. Moreover, her conclusions speak plainly to topics already critically engaged with above, as well as within my study more broadly. Firstly, they reproduce the notion of ‘culture’ as a variable that can be be instrumentalised toward biomedical ends, which I explored and critiqued in Chapter 3. Secondly, they draw on the now well-established emphasis of Norwegian public health perspectives that privilege a nutritional account of foodways in relation to health, and locate responsibility for this clearly within the individual (the mother-to-be in this case). And thirdly, through applying a particular rhetoric regarding dietary choices – “healthy eating” – Garnweidner applies a discourse of morality, one that is nevertheless couched firmly within particular biomedical and Norwegian notions of normativity. In identifying and examining these themes and relating them to the foodways of the Nepalis I encountered, I seek to challenge such (dominant, potentially dominating) assertions and instead show how alternative evaluations of food and wellbeing can and do co-exist within Norwegian society.

Garnweidner’s research is interesting, detailed and thorough, and offers useful insights into the reception of antenatal advice by women from various backgrounds. Nonetheless, as previously stated, it falls very much within the discipline of public health. Therefore, aside from its individualist and individualising emphases, it presents biomedical assessments of foodways as normative and employs terms such as ‘healthy eating’ and ‘nutrition’ in uncomplicated, undifferentiated ways. This is understandable, since it aims to speak directly to and potentially complement and improve existing antenatal care within the Norwegian health system. In contrast, the anthropological nature of my enquiries sought to engage with the antenatal and post-pregnancy foodways of the Nepali women I spoke with along broader lines. It was my aim to consider their habits and practices as much as possible on their own terms, and how they relate to maternal wellbeing (see next chapter) as well as health more generally (Chapter 4). Nevertheless, alongside the ante- and postnatal dietary guidance already discussed, Garnweidner’s research provides an important basis for comparison and reference.

Discussion

At present, dietary guidelines for pregnant and breastfeeding women published by national health authorities in Norway, such as the Helsedirektorat (2009, 2011a) and Matportalen (2011a, 2011b), make repeated reference to *næringstoffene* (Nor: nutrients) within their advice on what expectant and new mothers should and should not eat. And as the above analysis of

such dietary guidance shows, food is widely presented according to whether or not it is ‘source’ of specific nutrients, or a means to improve the uptake of a nutrient. Taken together this speaks to a regard for food more in line with the aforementioned ‘nutritionism’ – that is, ‘medicine as food’.

The health and health-allied authorities in Norway evidently make particular efforts to provide comprehensive antenatal dietary advice for women pregnant there – albeit fully accessible only to those able to read Norwegian. Garnweidner’s Oslo-based research shows that the antenatal period is viewed through a public health lens as a significant site for recruiting women to ‘healthier’ eating habits – especially immigrant women, identified as ‘at risk’ of developing certain illnesses, notably diabetes. Through a detailed discussion of both the Norwegian guidance and Garnweidner’s research, I have sought to highlight the extent to which the formal, biomedical understandings of health dominant in Norway in relation to women’s diets before and shortly after giving birth, attend almost exclusively to the time before, i.e. to pregnancy. Therein, the major focus is on eating ‘healthily’, as framed within the paradigm of nutrition (itself biomedically-defined), and – in the case of the guidelines – ‘safely’, that is avoiding certain (again, biomedically-defined) food-borne pathogens. The diet needs to be ‘healthy’ readers are told, to enable ‘healthy development’ of the foetus; it needs to be ‘safe’, so the foetus is protected from exposure to the potentially lethal pathogens. And while beyond the scope of this thesis, given the dominance of biomedicine within other developed countries and increasingly elsewhere, there is reason to think that these emphases – on the developing child, in the antenatal period, and the ‘nutritionist’ accounts of foodways within that – are also widespread and growing.

Meanwhile, the information and advice on eating given to mothers in Norway during the postnatal period is, as we have seen, considerably less substantial, and mainly in reference to breastfeeding. There again, particular attention is paid to the effect on the infant. As already detailed, the mother’s diet is presented overwhelmingly as a vehicle for the transfer of appropriate nutrients to the child. Where effects on the women’s own bodies are discussed, it is more in relation to weight. And although active attempts to lose weight are discouraged, so are sugary and higher fat containing foods because of their lack of ‘nutrients’ and high number of calories. That the chocolate, cakes, soft drinks, ice cream and snacks that they cite as examples of such food might taste good, be pleasurable or in any way otherwise satisfying – for example, experienced by those eating them to be energy-giving, perhaps – receives no acknowledgement. The reference to calories, meanwhile, can, I would suggest, be read as a tacit warning against weight gain. One can readily set against this the experiences of the Nepali women I spoke with,

described in the next chapter, who spoke of the beneficial physical and emotional effects as well as satisfying tastiness of specific foods prepared for them postnatally.

Overall, the use of nutrition-based rhetoric in the postnatal advice accords with the underlying current going through all of the official guidance, and to some extent also implicit within Garnweidner's work as well, which tends to treat food as a composite of nutrients – 'medicine as food', the discourse of nutritionism (Pollan 2008; Chen 2009). Although there is mention at least once that "food should taste good" (Helsenorge 2014b), it stands out very little amidst the welter of details and suggestions about how to eat a "healthy and varied" diet (see, for example: Helsedirektorat 2009: 18; Matportalen 2015a).

The intertwining emphases apparent within the Norwegian official antenatal and postnatal dietary guidance are thus the health of the child-to-be and then infant, and the role of a nutrition-based language and reasoning in achieving this. While women's health and wellbeing within this is referred to, it is less obviously promoted, instead rendered apparently self-evident within the calls for and instructions to the individual woman on how to follow 'healthy' eating habits. A line in *Svangerskaps boken* captures the combination of these emphases particularly well: "The child's needs take precedence over yours, so if you have poor nutrition, you are the one who suffers first" (Sandvik 2014a: 32).⁵⁵

Garnweidner's research goes some way to restoring the place of the woman's body and wellbeing within pregnancy-related foodways, by focusing on women who were deemed at risk of developing conditions injurious to their own health, albeit also potentially to their unborn child. The dietary information and eating habits that the health personnel whom Garnweidner worked alongside were attempting to inculcate in the women were intended to benefit their health longer term. Nevertheless, it is impossible to miss the judgemental, moralising tone present in sub-study three's division of its subjects into three groups: "*the healthy changers* became more concerned about healthy eating and aimed to continue with healthy eating after pregnancy; *the temporary health forciers* tried to eat healthily only during their pregnancy; and *the unhealthy vacationers* perceived pregnancy as a 'time-off' from healthy eating". (Garnweidner 2013: 38 – original emphases retained). The research concluded hopefully, asserting that "an individually tailored communication approach" might improve Norwegian public health efforts to impart nutritional information to immigrants (ibid: 61). Garnweidner was clear, moreover, that the women she interviewed were interested in and receptive towards

⁵⁵ Translated from Norwegian: "*Barnets behov går foran dine, slik at dersom du har dårlig ernæring, blir du den som først lider.*" (Sandvik 2014a: 32)

receiving nutrition-related information, especially at the start of their pregnancies (ibid: 47). However, her acknowledgment that towards the end of the pregnancies “participants experienced an overload of health-related information and had problems recalling all the information received during antenatal care” (ibid), while understandable is also telling. It implies that much of what they were told was simply not that memorable.

More broadly, ideas of ‘normalisation’, self-regulation and morality are clearly evident within the Norwegian public health guidance and research regarding dietary habits and practices of pregnant women and those with infants, the work of Foucault (1991a, 1991b), Coveney (2006) and the Norwegian anthropologist, Middelthon (2009) all relevant to this thesis. As in Chapter 3, the official maternity-related advice presented here again shows stereotypical bodies and subjectivities being presented – and potentially produced – this time the individualised, selfless and always-responsible mother, whose own health is essentially eclipsed by that of the individual child. In my study I have tried to draw attention to this relative elision of the mother’s wellbeing within Norwegian public health guidance and research: through the close reading and analysis of official publications above; yet also in the coming chapter, by considering how the Nepali women I encountered in and around Oslo not only experienced pregnancy and the postnatal period but also engaged with local public health initiatives and structures. What my work suggests is that despite a notable commitment to gender equality in Norway (see Chapter 2), there is a distinctly less parity afforded to women in relation to their unborn or new child, at least from a biomedical, public health perspective. And yet, as we shall see, among the Nepalis I worked with the health and wellbeing of a new mother were accorded considerable significance.

Comparisons between the Norwegian state guidance and any equivalent ante- and postnatal dietary advice from Nepali state-endorsed medical services would be interesting to make. Not least, it might give an indication as to what extent the privileging of the mother’s individual responsibility for self-care while pregnant and in the postnatal period, as well as the primacy of the child’s (unborn and then as infant), are intrinsic to a biomedical approach to motherhood, or the impact of other influences such as cultural practices. Such investigations are beyond the compass of this research, where the focus was on how Nepalis interacted with the information found in their diasporic home. However, for further or future studies this would be a valuable line of enquiry.

Conclusion

The nutritional recommendations published by Norwegian health and food standards institutions and implicit in public health research carried out there, assume an authority and carry certain

expectations of state subjects that they will be adhered to. As this chapter makes clear, the emphases conveyed in state-endorsed ante- and postnatal guidance, as well as in recent public health research, demonstrate an approach wedded firmly to a biomedically-predicated, nutrition-based account of food ('medicine as food'), which is focused heavily on the antenatal period and distinctly geared towards the health of the child. This is in clear contrast to the coming chapter, which will show that among the Nepalis I worked with biomedical theories could co-exist with alternative appreciations of food during pregnancy and its aftermath. Moreover, for my respondents the postnatal period was treated with special significance, a major focus at that time being the new mother's health.

Furthermore, by analysing Norwegian public health approaches to maternity, the prominence and responsibility accorded to the individual becomes readily apparent. Whether it is through the overt identification of the mother alone in ensuring the appropriate health and safety of her diet, or in the clear separation of the bodies of mother and child (before as well as after birth), in both cases maternal wellbeing conveyed as secondary to that of the child. From all this emerges the production of a kind of stereotypical figure of the individual mother that is, paradoxically, elided by the overwhelming focus on the child. Specific perceptions about personhood and (in)dividuality in relation to pregnancy were not readily apparent among the Nepalis I worked with. However, as will be seen, a more collective sense of responsibility for the health of the mother and child was, together with a seemingly greater prizing of the woman's own health during the process – more than was evident anywhere in the Norwegian research I came across.

The overprivileging by Norwegian state-endorsed advice and public health research of the individual mother's responsibility for ensuring her own health so as to benefit the coming or newly-born offspring (ignoring the potential for alternative distributions of responsibility for, as well as focus on, both offspring *and* mother), is the third key argument of this thesis. Moreover, as this chapter has shown, the hegemonic account such official bodies present of what is 'normal' is built on a very culturally specific interpretation: that of a biomedically 'sound' approach based on a regular Norwegian diet. These normal and 'normalising' intentions, and the implicit emphasis on self-responsibility, self-regulation and morality that are bound up in following the 'healthy' foodways outlined by Norwegian public health literature, are thus revealed. Here this has been through a critical examination of texts, which shows how the recommendations (and expectations) explored within the official public health discourse and literature are circumscribed by certain biomedical models, as well as notions of normality and of the individual. And it is in the next chapter that these ideas are challenged, and the contingent nature of the Norwegian position – with its normative biomedical assumptions and foci – further exposed. Speaking to the second key argument of this thesis, I look once more beyond existing

biomedical and public health accounts of foodways, this time by examining my Nepali respondents understandings of appropriate ante- and postnatal dietary habits and practices of care.

Chapter 6 – Nourishing the Mother as well as the Child: Ante- and Postnatal Foodways of Nepalis living in Oslo and Ås

“I don’t know in Nepal we think so much what we eat in pregnancy but it is after, after the birth [that] we think more about it.”

Sonya, Nepali mother of one child, living near Oslo

“After the birth of my second child there were many friends around [at her home], making food for me, teaching my husband what he should do.”

Annie, Nepali mother of two, living in Oslo

In the previous chapters I have examined how and why Nepalis come to be living in and around Oslo (Chapter 2) and explored their dietary habits and practices in relation to health and wellbeing (Chapter 4). I have also reviewed Norwegian state-endorsed guidance and approaches both to South Asian immigrants’ health (Chapter 3) as well as to pregnancy and the postnatal period (Chapter 5). I now turn to the core of my dissertation, the ante- and postnatal foodways of the Nepalis I encountered in Oslo and the nearby town of Ås. Describing and analysing what my Nepali respondents related exposes ways in which maternal eating habits and practices during pregnancy and in the months following a birth accorded with and diverged from the state-endorsed advice and norms made available to them in Norway, discussed in the preceding chapter. Akin to Chapter 4, my ethnographic findings reveal a Nepali approach to pregnancy and postnatal foodways where biomedical theories could co-exist with other considerations of food. Prominent in this maternity-related context, however, was that the period following birth was of special significance, especially in relation to the new mother’s eating habits and practices. Moreover, concern for her wellbeing and bodily recovery seemed much more apparent among the Nepalis I spoke with, compared to the attention given to maternal health in the Norwegian postnatal guidance. This valuing of the mother in her own right – that, for my Nepali respondents, maternal needs were less clearly subjugated to those of the newborn – is the second of three main points that will be made in this chapter.

A notable way this valuation of maternal health manifested was in the efforts made by the Nepali female friends and any relatives also living in Norway to provide specific foods as well as support to the new mother in the months after the birth, strongly suggesting that the health of both mother and child (for they were the indirect beneficiaries) was regarded as a collective responsibility. This sense of group accountability stands in contrast to the highly individualising

accounts, predicated on notions of self-regulation, which have been shown to run through the Norwegian guidance and research discussed in Chapter 5. It also constitutes the first main analytical point of this chapter, namely, that for the Nepalis I encountered, social relations both during pregnancy and particularly in the early postnatal period mattered, a lot. It was not just the mother and baby that ‘counted’. Thus the atomised view of a purely mother-infant dyad so evident in the official Norwegian ante- and postnatal guidance and research is seen not to pertain in the same way. In South Asian communities more broadly, a sense of collective responsibility for health of women during pregnancy (and postnatally) has been identified: mothers and mothers-in-law are particularly prominent forces in determining a pregnant woman’s diet, frequently aided and abetted by numerous other female relatives who bring foods or prepare dietary prescriptions (Donner 2008: 105 - 6; Homans 1983: 78, 82). In such cases, an overt emphasis on the ‘individual’ mother-to-be as responsible for her (and her unborn child or newborn’s) health through a practice of ‘self-surveillance’ – so evident in the Norwegian guidance already discussed – would here be misleading. And this was borne out in my own findings, which, as will be seen, show similar efforts on the part of a woman’s Nepali family and friends to assist her, albeit most particularly in the postnatal period.

The place of social relations, especially collective responsibility, and emphasis on maternal wellbeing that this supports comprise two significant arguments put forward in this chapter. The third point made, however, is that in interpreting how they interacted with Norwegian health services and guidance, the middleclassness and attitudes towards the state of my Nepali respondents needs to be taken into account. Although not a major emphasis of mine during fieldwork, the Nepalis’ variable engagement with state ante- and postnatal guidelines as well as related infrastructure offers up some interesting indications as to their perceptions of state authority more generally. The impression I gained was of a considered and mostly willing engagement with pregnancy and post-natal services by Nepali women and their families, while at the same time retaining confidence in their own judgement as well as certain values and practices that would fall outside of any Norwegian foodways related guidance.

Taken altogether, the three analyses-based conclusions advanced in this chapter – the significance of social relations both ante- and postnatally for the Nepalis I encountered, their evident valuing of maternal health within this, and the relevance of their particular class- and experience-based background when interacting with state-endorsed diet-related health guidance and services – all indicate the need to look past the biomedical model towards the wider social, cultural, economic and political context in which all this is embedded. And it is through its ability to move past the biomedical framing so evident in the Norwegian guidance and research

detailed in Chapters 3 and 5 that anthropology's distinctive contribution to understanding this complex and composite situation lies.

More centrally still, this evidence of my Nepali respondents' foregrounding of maternal wellbeing and sense of collective responsibility therein, speaks to the third key argument of this thesis, acting to highlight the overprivileging by Norwegian public health literature and rhetoric of the individual: both of the individual infant(s) in relation to their mother, as well as the mother's individual responsibility for health of both themselves and their newborn(s). Meanwhile, accounts below of how the Nepalis I encountered balanced their own experiences, knowledge and class-status in response to state-endorsed ante- and postnatal guidance represent further expressions of both the second and fourth key arguments advanced in this work – respectively, the contingency of apparently hegemonic biomedical models of food in relation to health and wellbeing in Norway, and the perceived limitations among my respondents to state authority in Norway.

Antenatal foodways

I first met Nirmala at Nepali School, one snowy evening in December. Well-protected from the elements by a down jacket, she was otherwise quite casually dressed, in baggy tracksuit bottoms, a sweatshirt and trainers – it transpired that she lived a few minutes' walk from the community centre, in one of the flats that formed part of the complex. Together with her was a just-about walking little boy, a man and an older woman, who I subsequently learned were her son, husband and mother respectively. The little boy, Dinesh, was immediately the centre of attention for all of us in the room: tottering up to various people, then back to his mum or dad, to mutual delight judging by the smiles wreathing everyone's faces. Spotting me talking with Ravi and Annie, Nirmala came over and introduced herself to me in near-flawless English. During the rest of the time I was there, punctuated by visits from her son (who was otherwise being admired, dandled and generally appreciated by everyone else – men, women and the children when they came out from their class), we chatted and agreed that I could meet up with her another time to ask about foodways, health and related experiences around her pregnancy.

Nirmala was born in Pokhara and came to Norway aged thirteen, while her father was doing a PhD at the University of Ås. She settled in well, so when he had finished his studies and eventually moved back with his wife to Nepal, Nirmala decided to remain in Norway to complete her education, going on to gain a Master's degree at the University of Oslo. During this time, she met her husband, also a Nepali. They married and, both with permanent jobs, decided to remain in Norway at least for some years. Following her son's birth, she thinks she

will now stay at least until “until he has gone his own way, got a wife”, after which she and her husband might return to live in Nepal.

Nirmala had recently started back to work following maternity leave and her husband was on paternity leave – a further indication of how they had embraced the Norwegian style of parenting and childrearing. It was initially more convenient for Nirmala that we met in lunch breaks at her place of work as her evenings and weekends were largely taken up with spending time with her family, whom she was missing since beginning her job again. In between mouthfuls of salad, brought with her from home in a good-sized tupperware container, I heard about her eating habits and practices both while she was expecting Dinesh and in the months after he was born.

Nirmala’s is a good account to start with as she compares readily with participants from Garweidner’s (2013) research that looked at official dietary advice given to pregnant women in Oslo, discussed in the preceding chapter. Like several of Garnweidner’s respondents, Nirmala was first-time pregnant, an immigrant and South Asian, so deemed at particular risk from gestational diabetes. In fact, in addition to instructing Nirmala to take folic acid during the first three months of the pregnancy, her general practitioner had been explicit in stressing the ethnicity-associated risk: “My doctor, she always said I should train [exercise], I should avoid sweet things. Because we women who come from Asia and all those places, we have a very high tendency of getting sugar [diabetes]⁵⁶ during pregnancy or later in life. So she had always given me this advice.”

Apart from confirming that Nirmala was neither smoking nor drinking alcohol, the GP also suggested that she took *Tran* (Nor: fish oil), which she did, instead of the usual vitamin D tablets. This, the doctor had explained, was because the additional fatty acids helped in the development of a child’s brain. Beyond that, Nirmala remembered drinking a glass of milk and trying to eat three to four pieces of fruit each day while pregnant; the latter she found a bit of a struggle but was helped, she recalled, by leaflets from the doctor and midwives that explained a glass of juice was the equivalent to one portion of the recommended ‘five-a-day’, and to count vegetables as well – especially where sugar intake was a concern. This became relevant when her husband tried to suggest she limit her intake of mango (something she ignored, she told me laughing) having craved it throughout her pregnancy: “I was addicted to mangoes, I took lots of mangoes”. In addition to the formal medical guidance, Nirmala regularly checked the internet

⁵⁶ In all our interviews and conversations, Nirmala tended to refer to diabetes or gestation-related hyperglycaemia (raised blood sugar levels during pregnancy) as ‘sugar’.

site, *babyverden.no*. However, although this website offered numerous tips on diet, her interest was in the sections charting the baby's development, and she remembers paying no real attention to other information there.

Other advice and information about pregnancy-related foodways came from her family and friends. By Nepali standards, Nirmala came from a "very small family, with me, my Mum and my Dad. And we didn't live with the grandparents". Nevertheless, they made sure she knew to avoid bamboo shoots, *tito karella* (bitter gourd), papaya and *kupindo* (a type of squash), all considered potentially harmful to a pregnancy. For example, as Nirmala explained, "*kupindo*, they say you should completely avoid it because it kind of works like an abortion medicine. So if you take it the baby gets aborted." As will be seen, to varying degrees, these same foods feature in dietary proscriptions mentioned by the other women I met and spoke with.

All this said, Nirmala stressed that at least up until week 28 of her pregnancy, she had eaten "a normal diet: rice and all those things... I was eating everything. Everything I wanted". She had also continued in her administrative job as usual, working Mondays to Fridays. However, during week 28, when Nirmala attended a standard check-up with the midwife, her blood glucose level was found to be raised near to the upper limit. Consequently she was advised to reduce her intake of certain carbohydrates in particular: "to cut down on my rice, on my pasta". This medical guidance she tried to follow, instead eating "not so much rice, maybe a little bit more bread, *roti* and other things, all the sugar cut down, no more mangoes", and a blood test two weeks' later indicated that although still a bit raised, the level had fallen. A further check-up at 34 weeks, however, revealed that the baby had not grown as much as would have been expected, a scan confirmed this and glucose was also found in Nirmala's urine sample. Her response to this news was decisive: "I said 'shit' with all those – I have to eat... I didn't cut out anything, you know. I was scared that the baby didn't grow because probably I didn't eat the right things, you understand. He was probably not getting all the nutrition he should get, all those things... I said 'shit' with every *kontroll* [Nor: check-up]; I'm eating everything, what I want. And I told my husband, I'm not going to control it, it doesn't matter if I have sugar, I'm eating."

Beyond telling her to return for a repeat scan and glucose tests 14 days later, the medical staff gave no further advice (it is reasonable to assume that they would have thought Nirmala was continuing on the reduced-carbohydrate diet they had earlier advocated). During this period, despite previously having seemed to follow the biomedical advice given, Nirmala appears to have responded more instinctively to the situation, behaving in what was effectively almost diametric opposition to the medical guidance. No judgement is intended or forthcoming here,

even if Nirmala herself now considers those actions negatively: “that was really stupid actually”. Rather, what interests me is that such apparently contradictory behaviours were manifest. This is a point I will return to in the discussion. Here it is worth noting that Nirmala’s actions show that one does not know how much of any official dietary guidance is acted upon, nor, presumably whether a Norwegian woman in the same situation would have acted differently – although, given the aforementioned public health emphasis on South Asians risk of developing diabetes (see Chapter 3), the impression given is that the advice might have been framed differently had Nirmala not come from that region.

Results of the subsequent tests and scan revealed that her blood glucose level had risen dramatically, but also that the baby had grown and was now judged to be of normal size. Nirmala remembered being then worried for her own health, “I was scared that it [the high blood glucose level] might not go away; sometimes it becomes permanent, it doesn’t go away, you know,” so she cut out all rice, pasta and high-sugar fruits, eating *roti* morning and evening thereafter. By then her parents had come to stay (already organised so that Nirmala would have extra help at home), so her mother was preparing all the meals. At the same time, Nirmala hints at the ambiguity the medical situation had thrown up: “we went after fourteen days and then she [the midwife] measured him again, and then she said he was like three kilos. I said ‘three kilos, that’s normal, that’s completely normal’. And I thought, like, she had scared me for nothing.” Where Nirmala’s knowledge came from of what was ‘normal’ in this case was not clear. However, given the closer medical surveillance she was by then under, her use of the *babyverden.no* website as well as her confident demeanour, it is quite likely – given her clear concern about the situation as well as fluency in Norwegian – that she would have sought out such information directly, either from the medical staff or the internet site.

In fact, the food restrictions lasted only a week as Dinesh was then born (a normal, vaginal delivery) healthy, albeit a couple of weeks before his due date. As a newborn, he too had to be tested for raised blood sugar levels, blood samples taken by pricking his toes, something about which his mother acknowledged feeling “so guilty... it was like I should have, should have maybe controlled myself, but it was too late”. Happily, the little boy had normal blood glucose levels and Nirmala’s dropped in the weeks following the birth. It was Nirmala’s fluid interpretation and responses to the biomedical information and advice she was receiving that I find particularly striking about the above situation. Firstly, rather than focusing on the extent to which she did and did not follow biomedical guidance (as the public health literature reviewed in Chapters 3 and 5 would tend to), considering Nirmala’s experiences and actions on their own terms, in a more neutral way, allows us to view the official health input she received from a potentially more circumspect and questioning angle. And secondly, her temporary disavowal of

the medical dietary instructions she had received and following of her own instincts instead: this reflected a certain confidence in her own judgement at the time, which even if she questioned it afterwards, points to a perception of state-endorsed medical authority as limited. Although speculation, I would suggest based on my encounters with Nirmala, who came across as confident in her opinions, that taken together with her educated, middle-class background, she might have felt less need to defer to, or more able to act independently of, the biomedical advice that she had been given.

While none of the other women I spoke with during fieldwork had reported experiencing gestational diabetes during their pregnancies, there were several similarities to Nirmala's account that they described in terms of their pregnancy-related foodways and exposure to guidance and care. The two most noticeable features, surfacing repeatedly, were firstly that they remembered not changing very much about their diets during pregnancy in response to medical guidance (Nirmala's was the most extreme example). And secondly, that while each recalled having attended several doctor- or midwife-led *kontrolls* in the antenatal period, and that during these the subject of diet was raised and in some cases leaflets given to them, the actual content of these food-related conversations was not very memorable.

These themes are now considered further through examples from other Nepali women I encountered. At this stage it is important to specify the age range of the children (and hence pregnancies) being talked about. I did not come across any pregnant Nepali women during my fieldwork, yet one I got to know had given birth to her first child only a month earlier. The offspring therefore ranged in age from one month to – in one case – their early twenties, the majority of children being less than ten years old; consequently, almost all the pregnancies being discussed here took place within the last decade. Furthermore, some of the women I spoke with had had part or all of at least one of their pregnancies in Nepal. However, I will focus mainly on those who experienced being pregnant in Norway and hence were exposed to the formal antenatal information and care opportunities there.

Mira got pregnant for the first time very soon after arriving in Norway and had her son just about one year after coming to the country. Although now fluent in Norwegian and in a full-time job, at that time (six years ago) she remembers being at home, “cooking everyday”, and that she made no special concessions to her condition: “I ate as normal” and “avoided nothing”. Her husband (also Nepali and resident in Norway for more than a decade prior) used to accompany her to the medical appointments to translate but she cannot recall him mentioning anything in particular about what she should or should not eat. Mira went on to add that it was only subsequently, when she started working in the catering trade, that she learned about such

things, for example to avoid shellfish, raw meat and specific soft cheeses during pregnancy. She, as well as others, would point out that this was not difficult for them as none of those foods were typical in Nepal or in typically Nepali diets, although some did go on to say that had developed a liking for them since coming to Norway and trying them there.

“I didn’t think much about eating, what I should eat, what I should not eat during the pregnancy”. This was Sonya’s response to my question on the topic. And variations on this answer resounded throughout my enquiries with others. If anything there was mention of eating a little more in terms of quantity, in particular eggs, which were often cited as an important sources of extra protein. Avoidances noted by some, such as certain meats and boiled fish, were because they were deemed unappetising and “not for precautions” as one woman put it. Regarding their encounters with medical services and the advice received, most women recalled being advised to take folic acid, and in some cases iron and *Tran* or vitamin D, and a few remembered being told to avoid seafood and *mygge ost* (Nor: mould-containing cheese – for example, brie, blue cheese etc.); beyond that, however, very little. Several of the women recalled eating more fruits, but more because they felt inclined to do so rather than due to having been instructed to. Jyoti, a Master’s student, who has two sons under four, the younger just over a year old, remembered her midwife suggesting that she reduce her coffee intake slightly: “I was consulting with the midwife and I said I drink this amount of coffee a day [5 to 6 cups], so should I reduce or is it ok then? And she said, ‘ah, it is no problem but it will be better if you reduce a little bit’. So I stopped, I just took maybe two or three cups, because at that time I had exams, so I drank coffee, yeah”.

A notable exception to this collectively quite vague account of the antenatal food-related guidance received from Norwegian medical personnel came from the experiences of two women, Padma and Maya. Padma came to Norway when five months’ pregnant with her only child (a boy, who was 16 months old when I met them in Oslo). Maya, who had her first son in Kathmandu, had moved to Norway by the time she was pregnant with her second one. Both women had been prescribed iron, folic acid and calcium tablets while in Nepal – apparently a usual part of antenatal care practice there. However, on coming to Norway and asking their GPs for similar prescriptions, the women were told that at least in the case of iron and calcium, dietary sources should be sufficient. “I asked the doctor to have calcium and she said you can just eat cheese and milk, that’s it”, recalled Maya. Whether or not she thought this was a good thing, Maya did not say, adding only that she had gone on to develop vitamin B12 deficiency in the latter stages of that pregnancy and thus needed to take supplementary tablets. Padma, meanwhile, was positive about the Norwegian approach: “We have more emphasis in Nepal on, like medicines and vaccines. But here [in Norway] we have mainly focus on food so I feel that’s

better than in Nepal”. The prescription of calcium to pregnant women in Nepal could reflect a perceived lack in the diet there, however almost all the Nepalis (male and female) I met, while acknowledging that cheese was not common in their homeland, said they regularly consumed milk, usually in tea, as well as *dahi* (milk curd).

Indicating the significance of social relations in their antenatal care, what seemed to stick more firmly in the minds for some of the women I spoke with was advice from family and friends. This is perhaps unsurprising given that, as Annie remarked, “in Nepal, many things are said about food”. Echoing my findings regarding Nepali foodways in relation to health more generally (see Chapter 4), Annie went on to refer to the way that many foods in Nepal were regarded as having either ‘heating’ or ‘cooling’ effects, which might be more or less appropriate depending on the health or condition of an individual. Pregnancy was one such condition. Several of my Nepali respondents were then counselled by female relatives and friends to avoid certain, usually ‘heating’ foodstuffs. Papaya, bitter melon, *kupindo*, *pharsi* (another kind of squash associated with miscarriage) and *jimbu* (a chive-like vegetable again associated with the potential to cause miscarriage) were the main ones they mentioned. Pomegranate juice, meanwhile, was recommended to many as a source of iron. Ida, a Norwegian woman married to Nepali, while not recalling receiving any formal medical guidance on the topic of diet remembered well her husband’s female cousin (also living in Norway) telling her to avoid spicy food and onions because, due to their tendency to ‘heat up’ the body, they might also risk causing miscarriage. It is worth stressing that nowhere in the context of pregnancy (or postnatally) did I hear my Nepali respondents differentiating between the inherent attributes of Norwegian and Nepali bodies, and their propensity to respond to certain foodways in certain ways. Neither was a need to adjust the maternal diet to the colder Norwegian climate invoked – as it was by Ashok and Sonya, in Chapter 3, in relation to health more generally.

At least a couple of the women were encouraged by their mothers to eat more. One of them, Jyoti, speculated that it was because her mother “felt maybe I should eat more then the baby will be healthy and strong. So all the time she told me to take *ghee*, *ghee* and more fruits”. Jyoti did not oblige however: “I didn’t follow... I knew that the *ghee* is not the reason of making bigger and smaller, or stronger or weaker... it just goes in our bodies, it just makes big for us, not for the baby [laughs]”. That said, Annie, a qualified nurse, expressed confidence in her own judgement, especially in challenging certain food-related practices and proscriptions that she had come across in Nepal: “through my training I have learned that you don’t have to be so worried about food... I am less *skeptisk til* [Nor: wary of] many of the foods that they might say should be avoided... I didn’t feel the need to ask people what I should or shouldn’t eat”. Without explicitly describing the advice typical in Nepal as ‘old-fashioned’, both women

inferred that they had additional knowledge that enabled them to reject it. The sense I gained however was that this additional knowledge was couched in terms of education – Annie asserting her “training”, Jyoti simply saying that she “knew” – rather than as a means of presenting them as somehow more Norwegian, for example; both women were clearly proud of being Nepali and showed no obvious signs of trying to identify more with the country they were now living in.

The issue of women needing to have their husbands to translate for them in medical appointments arose in some of the other cases too. Many such appointments were, I heard, carried out in English. Most adult Norwegians speak English fluently as did many of the Nepalis I met, often equal to their Norwegian (which, where they had learned it, tended to be the more fluent of the two, as they used it more often in everyday life). Clearly, where any translations were required, there was considerable room for slippages and loss – not least of food-related information. That said, Ida, who as a native Norwegian speaker was able to engage directly with health personnel and resources, remembered her pregnancy “was the worst time” in terms of her eating habits. At that point she worked at a food and news kiosk and when it closed up for the evening the staff could take some of the food home with them, which consisted mainly of hot-dogs, white bread rolls and buns and other fast-food items. She recalls having been hungry all the time and, although the doctor had told her “to be careful about the weight”, Ida could not recall getting any particular information or advice on diet or eating from the doctor or midwife. While Ida’s case could be exceptional, it does suggest that such dietary or nutritional counsel does not necessarily get ‘lost in translation’. Moreover, it points to the possibility that biomedical discourse can be irrelevant, potentially alienating even, regardless of whether the person subject to it is a native to the country and fluent in that language or in English (a common ‘common language’ in much international communication), or both.

Upon prompting, several of the women I spoke with remembered looking on the internet at some point during their pregnancies, but recollections of exactly for what and which sites were checked (Norwegian, Nepali or other) were usually hazy. This could suggest on the one hand that as such a ubiquitous information resource, the worldwide web can cease to register as worth commenting on in the minds of its users. On the other hand, however, the women’s lack of emphasis on it as a source of advice or guidance – both during their pregnancies and in the postnatal period – might also point to the internet having been less significant to them in these matters compared, for example, to the much more readily remembered and recounted input from relatives, friends and, to some extent, medical personnel.

One of the more enlightening and light-hearted experiences of my fieldwork was being invited to Indira's home, one Saturday afternoon. Another teacher at the Nepali school, Indira had lived in Oslo together with her Nepali husband, Ravi, and their three children for over a decade. In a gesture of friendliness as well as help, she had kindly arranged a gathering of some her women friends, for me to meet them and us all to talk about my research interests. I had guessed there might be about five or so others there, including those I already knew to be friends of Indira's, such as Annie, Nirmala and Mira. You can imagine my surprise when, upon arriving, I encountered at least ten seated around a large dining table, with two more expected later on in the afternoon. The ages of the women ranged from late teenage up to and including late forties; at least two of the guests had adult children and had experienced those pregnancies and subsequent births in Nepal.

As the conversation criss-crossed the table, laughter, some bawdy asides and the occasional request from one of the numerous children (also invited but playing together in another room) punctuating proceedings, I heard about what sorts of foods the women ate (or avoided) during their pregnancies. As in the individual interviews, fruits were favoured by many, the iron-rich pomegranate judged especially good to eat - "everyone says that" Annie added, to surrounding nods. Among the younger women, who were usually the more confident speakers, the term "balanced diet" was used, a "general balanced diet" their recommendation. Given that many Nepalis are Hindu, I asked about any meat restrictions and was told that while eating meat during pregnancy was generally "ok", certain "religious restrictions" did apply, depending on the individual's family and caste-related practices. These played out quite differently within the group however; Annie and Indira said that as Hindus they did not eat beef, Nirmala also identified as a Hindu but said that in her family they did eat beef. Kusum, from a different caste and part of Nepal added that for some Hindus pork was also not allowed, although in her (Hindu) community, all big ceremonies would involve pork. Indira then chipped in to say that goat would be the important meat to have on such festive occasions. In sum, it became evident that any meat restrictions related to religion or different caste groups and not specifically to pregnancy.

The topic of food avoidances provoked a few debates. While papaya was singled out by almost everyone for its miscarriage-causing potential, Kusum remarked that she had grown up in an area where papaya grew in reasonable abundance and she thought it was not especially avoided there. Both honey and mango were suggested by some as risky in large quantities, too much of either considered "too warming", which could bring on miscarriage, but even knowing this Nirmala (as already mentioned) reminded me of how she had ignored that advice: "I ate it [mango] throughout my pregnancy, I was so addicted". Meanwhile, a couple of the women's

avoidance of pineapple during their pregnancies was met with murmurs of surprise and frank disagreement by others. The “rule” about seafood (shellfish, as opposed to fish), which those women pregnant in Norway seemed to remember most clearly from their encounters with medical services was, as one woman pointed out, “not a Nepali rule” because “we don’t have this [shellfish] in Nepal!” The overwhelming tendency expressed by the women present was that most of them changed very little about their diets during pregnancy, papaya and seafood the most common exclusions, although several simply “ate everything”.

Two of the older women present, Sasmita and Sonam, who had been pregnant and given birth to their now adult children in Nepal, explained that at that time there were simply not so many choices. Rather than being conscious of what might be good or bad for their health, they ate what was given within the family. Moreover, given that virilocal post-marriage residence was usual, it was the husband’s family, including the mother-in-law, who would decide the food of the household. In contrast, Kusum, also in her forties but married to a Norwegian, had lived in Norway during her pregnancies and had the advice of her Norwegian mother-in-law, who was a doctor. “I always took her advice... followed the medically advised ways,” Kusum said, for example not to drink full-fat milk because “it makes one fatter” and to have “*ekstra lett* [Nor: extra semi-skimmed milk – a type of milk available in Norway that is between semi-skimmed and skimmed in fat content]” instead. Consequently, Kusum considered her experience as “very very different” from Sonam or Sasmita.⁵⁷ What these particular women’s experiences suggested was that the source of advice (the mother-in-law) rather than the specific content may have been more significant in determining whether or not the women heeded it. This could, in turn, have indicated a respect for the older woman’s authority yet also a potential consequence of dwelling place – all the women lived either in their mother-in-law’s home (Sonam and Sasmita), or much nearer to their mother-in-law than their own mother (Kusum). In contrast, among the other (younger) mothers I encountered during research, all who lived in Norway did so as part of nuclear families: just them, their husbands and child(ren). Parents and parents-in-law visited but did not live with them. In these circumstances, therefore, the capacity for a mother-in-law to influence proceedings was considerably reduced, as was that of a mother (thinking of Jyoti’s ignoring of her mother’s pleas). We can see that in influencing pregnancy-related food choices, the significance to the Nepalis I worked with of social relations again shines through yet is mediated by geographical proximity, especially to key family members such as mothers and

⁵⁷ Kusum made a point that afternoon of telling me that, given her background of being married to a Norwegian and living so long in Norway, she was “atypical” and not the “right” person for me to talk with about Nepali foodways.

mothers-in-law.⁵⁸ As we will see, after the birth, the contributions of friends and relations who lived nearby (or resided temporarily in the family home) continued to constitute a really important part of my Nepali respondents' approach to maternal care.

Overall, it seems evident that official antenatal dietary advice, beyond folate and Vitamin D supplementation, was a relatively insignificant factor within the experiences of the Nepali women I encountered. While I have tried to delineate what patterns there were within their antenatal foodways and experiences, one of the most significant things during these encounters was the way in which, unlike the marked emphasis placed on the period by biomedical services, the women gave relatively little weight to it. This is not in any way to suggest that they were less careful or appreciative of their state, but rather because, to quote Sonya, the greater emphasis was elsewhere: "I don't know in Nepal we think so much what we eat in pregnancy but it is after, after the birth [that] we think more about it." Instead, and speaking to the first main argument of this chapter, the value of social relations – contact with and the possible influence of family and friends – seemed to matter at least as much, if not more. Also noteworthy is that despite now living in a country where so much official medical weight was placed on antenatal foodways, my Nepali respondents who had been pregnant in Norway appeared to remain relatively more focused on their dietary habits and practices following the birth – the second main point made in this chapter. Furthermore, and speaking to the chapter's third main argument, this suggests that for the Nepalis I worked with the authority of the biomedical accounts of maternal health as presented by Norwegian state services was limited; instead, during pregnancy and, as we will see, postnatally, the Nepali women I encountered could and did have the confidence to draw on alternative knowledge and experience.

Postnatal foodways

One bright, spring morning, I had visited Mira at the home she shared with her husband and son in one of the outer suburbs in Oslo. The first thing I noticed upon being greeted and invited in was that the slightly spicy, savoury fragrance I had grown so used to over years of visiting the homes of South Asian friends and colleagues was absent. Instead the apartment smelled very fresh, as if it had been recently cleaned. The reason for this emerged later as Mira was explaining how she cooked up a week's worth of *dal* as well as two or three meat and vegetable *tarkari* – "proper Nepali food" – on one of the weekend days, which she then stored in the fridge to be eaten throughout the week. This was partly because she did not have "the time or energy" after finishing work to prepare fresh Nepali food during the week, but also because

⁵⁸ It seems reasonable to assume that this could also be the case generally, not just among Nepalis. As not the focus of this thesis, however, such an assumption clearly remains speculative.

making this food created “a very strong smell”. In Nepal, where “everything is open”, she had said, gesturing to the windows, this was not a problem as the smell goes quickly. But in Norway, where homes were very well insulated and it was “often too cold to have all the windows open”, the smell stayed – something “I do not like every day, I must shower after I make food”, she had explained.

Having taken off my coat and removed my shoes in the entrance-way, she had bade me through to the pristine kitchen/dining room. A pan was set on the electric stove and Mira explained that she had made some *dudh chiya* (spiced milk tea, a Nepali specialty), knowing from our past conversations how much I like it. Asking if I had eaten breakfast (I had), she told me she was about to make “French toast”, and resisted my attempts to decline so as not to put her to extra effort. Thus about ten minutes later we were sitting opposite each other at the ‘breakfast bar’, plates of freshly-made ‘French toast’ and steaming cups of *dudh chiya* in front of us, and I had started to hear from my hostess about the days and weeks following the birth of her son, Nitesh, by then a sporty seven year-old and one of the star students at Nepali School.

As already mentioned above, at the time she gave birth, Mira had been in Norway only a year and was attending a further education college during her pregnancy. She had come from Nepal following her marriage but already had family in Oslo, an aunt and uncle having moved to Norway a couple of decades’ earlier. Mira recalled that Nitesh was born (in the nearest main hospital) in the evening and that the only food she had been offered afterwards was bread. “I was very surprised”, she said, a negative tone to her voice, but being “very hungry” she ate it. The following day, the hospital staff offered a warm meal including salmon, which Mira also spoke of without any enthusiasm. Instead, that same day her aunt came with a home-cooked meal, which Mira said she was “so happy about”. She went on to describe the food: “chicken, *jwano* [thyme seed], *jeera* [cumin], *jaiphal* [nutmeg], *aduwa* [fresh ginger], a little *lasun* [garlic] and *methi* [fenugreek], and rice”, together referring to it as “proper *sutkeri* mat [Nor: food]”. *Sutkeri* is the Nepali term used to refer to the period after birth. Although not a strictly defined length of time, I learned from my respondents that it was expected to last several months. The word cropped up repeatedly in relation to my conversations with Nepali women on the subject of postnatal foodways and, as will be shown a little further below, incorporates particular food practices.

For the next two weeks, Mira continued to eat this type of meal, twice a day (i.e. in the Nepali style). The first week she was at home and her husband prepared it each day, the second week she went to stay with her aunt, who then made all the food. For that fortnight, Mira recalled

avoiding vegetables “because they were cooling”, *dal* and spices,⁵⁹ both considered difficult for the baby to digest (via the breast milk). Although in Nepal it would have been usual, Mira said, for her to have rested “in *sutkeri*” for at one least month (“one year, if I was rich”, she added), and her aunt was keen for her to do so, Mira returned to college after only two weeks. She explained that she had not wanted “to stay at home”, that she had never done so in Nepal either, always gone out to work, to meet friends etc. She continued to stay with her aunt for several weeks, however, receiving help with her new baby and being cooked for, by this time also having started “to eat more normal food again” including *dal*, vegetables and spices.

All the women (and some men) who I spoke to about foodways during the postnatal period mentioned *jwano* (thyme seed). Its significance, I learned, was in relation to breastmilk production, several informants telling me that *jwano*’s efficacy related to it containing a lot of calcium – a notably scientific explanation, which would fit easily into the conventional Norwegian postnatal guidance discussed in Chapter 5. Most usually taken as a soup, *jwano ko jhol*, the seed was regarded as a key part of a new mother’s diet. A typical recipe I was given involved frying the *jwano* in a little *ghee*, together with powdered turmeric, powdered cumin and some fresh garlic and ginger crushed to a paste; water was then added and the mixture brought to the boil, after which it was ready to drink. At Indira’s afternoon gathering, there had been absolute agreement as to its value in helping breastmilk production. So effective was *jwano* judged, in fact, that, as Indira explained, “you can’t have too much, otherwise it [milk production] would be too much”. “*Jwano* soup” was the first thing Jyoti mentioned when I asked her about the kinds of foods she ate after giving birth. She went on to elaborate: “because I think and I felt also that if you have less milk, then if you drink that soup [*jwano* soup], make soup, then of course the milk will be improved”. In fact, the spice’s presence in accounts of the Nepali women’s postnatal diets seemed to be ubiquitous, its breastmilk-enhancing capacities ‘common knowledge’, most people merely mentioning it and not stopping to explain the reason for its presence unless I had specifically asked. Even Maya’s husband, Nayan, who (as we will see later on) was roundly sceptical about other aspects of Nepali-style postnatal eating habits, asserted *jwano*’s efficacy in relation to lactation.

⁵⁹ As already mentioned in Chapter 4, when the Nepalis I worked with spoke of ‘spices’ they were usually referring to chilli and any other especially pungent culinary additions, rather than to less powerful-tasting condiments such as cumin, fenugreek, turmeric, nutmeg etc. – to which the term ‘spice’ is generally applied by native English speakers and also by Norwegians (*krydder*, the Norwegian word for ‘spice’).

In addition to the *sutki* meals, Mira's uncle also made and gave to her some *sutki masala*. *Sutki masala* (also known as *sutki ausadhi*) was another element of the Nepali postnatal diet described, and taken in some form or other, by most of the women I spoke with. At Indira's gathering, for example, my mention of it had provoked instant noises of recognition from around the table. Asking about the ingredients, I had then been told, "oh, it is so complicated" by Annie, a response met with laughs of agreement from the others. Exact formulations seemed to vary between the people and families I spoke with, and, I was told, from region to region as well as between different ethnic groups. Nevertheless, by taking together all the descriptions gathered during fieldwork and cross-referencing them with information from food blogs written by other Nepalis (Taste of Nepal 2015; The Mom side of Me 2015), I learned that *sutki masala* essentially consists of ground spices, ground nuts (often cashews, almonds, walnuts), dried fruits (dates, raisins), and edible gum (*gundh*) that, in these separate groupings, were fried in *ghee*, before all being combined together with boiled milk, to form a thick, brown paste that would harden into a kind of fudge-like consistency. This could then be stored in the refrigerator for several weeks or, as several of the women I met had done, divided into smaller portions that they deep-froze, in which case it kept much longer. Although not the most aesthetically appealing food (being brown and variably lumpy), it was considered by many to be delicious and, while particularly aimed at postpartum women, was a sweet that could be enjoyed at other times – evinced by Maya's husband, who, while clear he thought it unnecessary as a postnatal food, nonetheless admitted "it tastes good".

The particular spices (referred to by some as *batissa*) that were used in *sutki masala* were considered to have medicinal properties, in line with Ayurvedic theories. A few of the women described how their family members had visited special Ayurvedic pharmacies back in Nepal, to obtain the appropriate combination, dispensed as a powder, which they then either posted, made up into the finished article and then posted, or brought along with them when they next visited. From what these women said, it seemed that what the exact prescription of spices was might vary. In any case, it was not strictly necessary to use the shop-bought preparations – it was apparently entirely possible to make a suitable mixture at home. Regardless of the *masala* (mix) ingredients' origins, such a rich combination of ingredients was deemed necessary after birth for at least three reasons: to 'warm' the mother and give her help restore her energy; to help "tighten" her womb and abdomen, loosened in the process of giving birth; and to enhance the flow of breastmilk – a feature, as we have seen, especially associated with the spice, *jwano*.

The form in which *sutki masala* was prepared seemed to vary: for some, each 'serving' involved the powdered spices being fried together in *ghee* with the nuts and sugar, the whole lot then being boiled together in milk; for others it could be broken off from a larger block, the

selected piece then heated in some way, often through dissolving it in warmed milk. Nevertheless, in whichever case, the usual practice was to eat it warmed in some way. There was also variation in when the mixture could be taken. While most agreed that a woman could not take it straight after giving birth, the newborn unable to tolerate the spices (passed on in breastmilk), Annie began having *sutkeri masala* after one month, Mira after two months, while Indira and Nirmala waited until three months after giving birth. The Nepali-authored blog, ‘The Mom side of Me’, meanwhile, infers that *sutkeri ausadhi* could be eaten less than two weeks following childbirth: “This [*sutkeri ausadhi*] is made after the 11th day after birth, so that the body can recovery (*sic.*) from all the post delivery effects” (The Mom side of Me 2015). The frequency with which the women I spoke with had *sutkeri masala* varied; some had a spoonful with every meal, others once a day, and others less often than that. Nirmala, for example, recalled: “I didn’t have it everyday. Maybe here and there... when I felt like having one”. For how long they continued to take it was also a personal choice, although several continued for some months, as long as they were breastfeeding for example.

While Mira could not remember exactly how long she had taken *sutkeri masala* after Nitesh’s birth, she did in fact have some in her freezer when I visited and, given the nature of our conversation, was keen that I tried it. This I did willingly, curious to taste something that seemed to be such a consistent part of a postnatal diet for many of the Nepali women I had encountered. There were actually two different types to try: one batch made by Mira, another that her mother (who had recently been over visiting from Nepal) had given to her. Both were slab-shaped, with the proportions of a medium-sized chocolate bar, albeit irregularly contoured. Brown and textured with what looked like chopped nuts (cashews, I subsequently discovered), Mira’s was the paler of the two and had a crumbly texture. Very sweet and rich-tasting she said, with a smile, that it contains “very much *ghee*”. Her mother’s version, meanwhile, was considerably darker and more like a thick paste. Rather than sugar, it had been made using *chakku* (molasses). It had fewer nuts in it, was less sweet and the flavour seemed overall a bit more complex, notes of distinctly savoury-tasting spices detectable as I had moved it around the inside of my mouth. Slightly surprised that Mira would have at hand what I thought was a food more specific to new mothers, I had asked her about that. She then explained that while it was necessary for the mother to have after giving birth, it could also be eaten at other times. While she did not elaborate further, from the way it was spoken about by others it would seem that the energy and warmth giving properties of the mixture, taken together with its Ayurvedic spicing, could render it a kind of tonic or pick-me-up, suitable also especially for children, the elderly and the undernourished.

Beyond the *sutki* foods provided by her relations, I had asked Mira if she received any other advice or guidance about postnatal diet. The day following Nitesh's birth, she had spoken on the phone with her mother (in Nepal), who had told her to "eat only warm food and *sutki* food". Beyond this, however, Mira recalled no other food-related information, from medical personnel for example. Although she thought they may have been given some breastfeeding leaflets, which her husband would definitely have read and told her about, she could not remember anything about them when we spoke.

Drawing on Mira's story, there are three main points (and similarities) in postnatal foodways that resonated with the accounts of the other Nepali women I spoke with. Firstly, was the food, whether Norwegian style or Nepali, that was eaten by the new mothers in the hours or days immediately after the birth, and their reactions to it. The second point concerned the types of meals eaten by the women for the weeks or, in some cases, months thereafter, including the consumption (or not) of *sutki masala*. And thirdly, the extent and nature of the guidance about diet received by the women following the birth. That the Nepali mothers I encountered placed such significant weight on feeding of the mother in the postnatal period, wherein certain types of Nepali-style food or ways of preparation were preferred by many of them, reflects both this chapter's second main point (the valuing of maternal wellbeing), as well as the second key argument advanced in the thesis: the need to look beyond biomedicine's dominance in Norway to appreciate more fully how certain people living there balance multiple understandings of health and wellbeing in their foodways. Regarding information on and preparation of their postnatal diet, meanwhile, the centrality of social relations – especially with friends and any relations living in close proximity – speaks to the first point made in this chapter, and the third key argument of this thesis: namely, the contrast between the more collective sense of responsibility for (as well as focus on) maternal wellbeing shown by the Nepalis I encountered in comparison to Norwegian state and public health approaches, and the value of understanding better alternative ways of being such as these Nepalis demonstrated.

Initial meals following the birth

Every woman I interviewed on the subject had given birth in hospital. Following the delivery of the baby, understandably tired and hungry, several – like Mira – had expressed dismay at the food they were offered. Indira recalled the "cold food" and "lots of cold 'iced' drinks and water" at the hospital. Annie, who was five days in hospital following the birth of her first child, remembers having been given "cold milk" just afterwards and subsequently "eating food from the hospital canteen, Norwegian food, like the other [Norwegian] patients". At that time she had imagined that if she had told this to her mother or friends back in Nepal they would have told her that it was "totally the wrong thing to be doing", i.e. to eat cold food. Unlike Mira, at that

time Annie did not have an established network of Nepali friends or family in Oslo and her husband was not, by her account, able to cook (he can now, “well”, she added). Apparently destined to have to rely on the hospital catering, she was “overjoyed” when a “a lady from outside Oslo”, the wife of a Nepali work colleague of her husband’s, came to visit Annie twice (once in hospital, then again when she was home), bringing with her “Nepali food – chicken soup with *jwano*”. Back home only two days after the birth of her second child and by then with “many friends around, making food for me, teaching my husband what he should do”, Annie recalled the same “cold” food in the hospital but that her necessary exposure to it had been minimal.

Sonya also commented on the nature of the food given following her daughter’s birth: “I was so hungry, and then I asked [the nurses], ‘I am very hungry’ and I remember I got two pieces of bread with some cheese and a glass of milk. That was the food available. Very strange.” She had been living with her (Norwegian) husband in the northern city of Tromsø at the time, and because the birth was a little premature, mother and child remained in hospital for three weeks. Happy for the extra support the hospital could provide (“it was good because my husband was busy at work and I was scared to come home with this little baby and do everything alone”), the food situation had continued to be less than Sonya would have hoped for: “I didn’t eat meat and I asked if I could get fish everyday but I didn’t get fish everyday, but bread, mostly bread”.

While she did in fact receive food from outside (see below), within what the hospital provided, Sonya ate mainly cereal, yoghurt, fish (when available) and the inevitable bread. Where possible she supplemented this with any cooked vegetables on offer. One day however, her newborn daughter developed excessively loose stools and Sonya recounted how a nurse had questioned her: “‘Have you eaten vegetables, lots of vegetables?’ And I said ‘yes’ because I didn’t know it’s not good for her because it will go through the milk”, as the nurse had apparently subsequently explained. Thereafter, until she stopped breastfeeding, Sonya ate relatively few vegetables.

My conversations with Sanjay, a Master’s student, revealed that men too were concerned about a new mother’s postnatal diet. When I met him and his wife Mangala, they were the proud parents of a 3-month old boy. In their functional university-accommodation flat, a few homely touches added, softening the effect (not least a small Nepali flag standing on a shelf), Sanjay had described his impressions of his wife and son’s relatively recent stay in the local hospital. Due to a long labour and then the little boy developing an infection, mother and child had remained there for nine days. While complimentary about the medical care given to his son and the advice on breastfeeding, baby massage and bathing that his wife received, he was openly

critical of the food. “Until three days it was quite good. I respect. Warm food and the food is very suitable for the pregnant [*sic.*] woman... Then after three days they shift us to the newborn department. The department was only for the child but they don’t care about the mothers. And they give us food like coupon, and go and take the food from the canteen. The food was worthless... [I was] not happy. It’s cold, no good... And then I came back home and made food and go back again [with it] to the hospital”. Evidently frustrated, he had later reiterated his point: “After three days they [the hospital] give us this coupon. It is not a good idea. They should give us the food to the pregnant [*sic.*] woman because she is also important you know, in that context, so not just the child is important. She is also important.” Once home, Sanjay continued to prepare most of the food, at least for the first couple of months, however (translating for his wife, who spoke little English and no Norwegian) I learned that she had recently begun doing much more of that again.

Fortunately, in most instances, women’s hospital stays were much shorter and mother and child had returned to their homes within a few days. There, as has already been suggested and reflecting the emphasis placed on maternal wellbeing by the Nepalis I encountered, it was usual for similar care and efforts regarding the new mother’s diet to continue. Again demonstrating the central place of social relations within postnatal care demonstrated by my respondents, this attention and accompanying culinary efforts were often the province of female friends or relations, yet, like Sanjay, some of the men also took an active part. For example, although he had never made it before, following the birth of their first child, Indira’s husband Ravi took responsibility for making his wife’s *jwano ko jhol*, using a recipe she had given him. Talking about some of the non-biomedical food-related practices and proscriptions common in Nepal, Ravi, a doctor, explained that even though his professional training meant that “I don’t believe in those kind of things”, regarding *jwano*’s effects in improving breastmilk production he had to admit that it seemed to work. He had then added that while he might not agree with all of Indira’s food beliefs, he would never force her to change them.

Meals in the weeks and months following the birth

One of the strongest indicators of how seriously the Nepalis I worked with regarded a new mother’s wellbeing (as well as it being a collective responsibility) was that for the majority of women I interviewed it was usual that Nepali friends or relations (often the mother) either came to live with the new mother and child or at least were in regular and close attendance. And in both cases their principal means of assistance was in preparing meals. Following the birth of Indira’s children, for example, Kusum (who lived an hour’s drive from Oslo) had visited her regularly, to make Nepali food and “*jwano* soup” in particular.

Several examples have already been given as to the types of food eaten by most of the new mothers during the postnatal period. Jyoti recalled in particular having “*jwano* soup” regularly following the birth of both her sons, either simply as *jwano ko jhol* or “sometimes with chicken, vegetables, but once a day I used to take it”. In the initial weeks post-birth, friends and her husband had made the *jwano*-infused soup and other meals. Although her mother recommended it, even offered to send it to her, Jyoti did not have any sweet *sutkeri masala*-type foods. This she had explained was partly because she does not like sweet things but also related to her weight. “I was thinking that this [pointing to her younger son, who was ambling about the room] will be my last child... and I was just thinking that I should be, make fit my body”. So, while taking *jwano* she was having much less of the other more traditional *sutkeri*-type foods, adding “[with] the first baby I took all of the *ghee*, and milk, so [many] fatty things” but that this time she was trying not to do that.

Thankfully for Sonya, during the initial three weeks in the hospital, her brother and Nepali sister-in-law, who also lived in Tromsø, were on hand: “everyday, once a day, they came with food from home because they know that I don’t eat meat and I don’t get enough nutrition from the food in the hospital. So she [Sonya’s sister-in-law] sent food every day and I remember every day a thermos with *dal* or cooked beans with soup”. Both the *dal* and the dish of cooked beans (or sometimes lentils), which Sonya told me was called *kwaanti* in Nepali, were cooked with *jwano*, either in butter or *ghee*. Freshly cooked rice accompanied the thermos, along with a sweet comprising different kind of nuts, butter and sugar. I had asked if this was *sutkeri masala*. Sonya, a Newar, then explained that while they have a very similar concept to *sutkeri masala*, “to get calories... that you give to the woman after birth”, in Newari terms it was more usually known as *gudhpak*. Usually made at home, she said, it involves combining *gundh* (edible gum) with *ghee*, *chakku* (molasses), different types of nuts, a little flour and, if using any, Ayurvedic herbs (as can be seen, Sonya’s recipe bore distinct similarities to the *sutkeri masala* described above). In addition to the energy-giving and breast milk-enhancing properties, Sonya was clear that the *gundh*, considered to have medicinal properties, was believed to help restore the womb to its more normal dimensions. Sonya ate a “big portion” (gesturing approximately golf-ball size) each day following the birth and carried on with it for some weeks once she was home, her sister-in-law continuing to bring the Nepali meal once a day.

In the case of Sanjay and Mangala as well as Nirmala and her family, when the babies were a few months old, parents and child went to visit and stay with family back in Nepal. There, one can reasonably assume, appropriate regard and care would have been given to the new mother’s diet as well. In fact, one of my informants, Maya, whose first son had been born in Nepal, recalled what was apparently a usual *sutkeri*-style post-birth routine there. Having left the

hospital, she had returned to her parents' Kathmandu home for the first couple of months, where she was given meals of rice (often with *dal*, vegetables and egg – Maya did not eat meat – to accompany), *ghee* and *chakku*, four times a day, although she stopped having the *chakku* because she had haemorrhoids, which the *chakku* apparently exacerbated. In addition, “a woman would come twice a day to give a mustard oil massage” to both Maya and her son. This pattern did not recur following the birth, in Norway, of her second son. Her husband gave her massages a couple of times (“not with mustard oil, probably body lotion”) but her meals – still mainly Nepali in style – were reduced in frequency. “Nobody cooked *sutki*”, Maya recalled, “one friend came to me with *jalebi* [Hin: a bright orange, oily, syrupy pastry, a popular sweet of Indian origin]. You know *jalebi*? It's a sweet dish, which is also popular in Nepal. In *sutki* they eat it. A sweet dish. Also it gives, it has a lot of sugar and helps in lactation... [the friend] made herself and came with it”.⁶⁰ Laughing at the memory, Maya told me that she proceeded to eat this “almost every day. In the breakfast” for the time it lasted. A Newar, like Sonya, Maya did not describe eating any other kind of *sutki masala* (or *gudhpak* for that matter), but from the above explanation it seems that *jalebi* had functioned for her in a similar way. Maya also mentioned having *jwano* soup shortly after giving birth but then stopping because she actually produced more milk than she could use: “I used to pump and throw the milk”.

Additional evidence of the care that the Nepalis I spoke with took over a new mother's diet during the postnatal period was in the attention given to Ida's diet by her Nepali family-in-law. As you may recall, Ida was a native Norwegian married to a Nepali man with who she had an eight year-old daughter. Although Ida had family of her own in Norway, it was her husband's aunt (also living in Oslo), who came to stay with them in the months following the girl's birth, making daily meals of “chicken with gravy, rice, soup, vegetables and *dal*”. Ida recalled the older woman also preparing a kind of porridge of warm maize flour, milk and water, served for breakfast and lunch. According to her husband, Devi, Ida had no *sutki masala* (Ida was unfamiliar with the term), which he thought may have been because her aunt's family were “quite health conscious”. In fact, Ida described the aunt's daughter, who has lived in Norway since the age of eleven, as being “more Norwegian than Nepali”, going on to credit her husband's cousin with having “inspired” Ida and her family to eat “more healthily”.

While specific preferences may have differed, the usual postnatal foodways of the Nepali (or, in Ida's case, Nepali-related) women I met comprised in essence of regular warm meals of rice, a soup of chicken or egg and maybe some vegetables, the presence of *ghee* and certain spices,

⁶⁰ I later learned that there is a slightly different word for these sweets in Nepali, namely *jiffli*. Maya, however, referred to them as *jalebi* (the Hindi term for them).

specifically *jwano*. A key assumption, expressed by many I spoke with, was that the woman's body was thought to be 'cold' following the birth, so foods were given that were supposed to help with 'warming' it. Concomitantly, 'cooling' foods and drinks were to be avoided although this was not often practical, especially within Norwegian hospitals.

It is worth adding that even those without obvious direct experience of pregnancy or childbirth demonstrated knowledge of, and stressed the importance, of certain postnatal foodways. Married yet without children, Pinkee had lived in Norway for more than a decade and during that time studied nutritional sciences. In keeping with her training, phrases such as "protein rich foods", "green leafy vegetables", "calcium-rich food" and "a balanced diet" were a strong feature of what she considered appropriate ante- and postnatal foodways. Nevertheless, she made particular mention of "foods that help with lactating", swiftly following this with mention of "*jwano* seed", used in Nepal she said because it was "very calcium rich". Ashok, a man in his fifties, also spoke of the significance of *jwano*, recalling it in "the talking of my mother and sisters" on what should be eaten after birth. Keeping the new mother "warm" was something else he also recalled as important, a factor also picked up on by the newly-wed, Prithi, who I met over dinner at the apartment home she shared with her husband in one of Oslo's suburbs.

Married less than a year, and in her early twenties, Prithi had only been in Norway a few months, coming to join her husband (a doctor) who had already been studying in Oslo for some years. Although not yet a mother herself, Prithi spoke with confidence about certain maternity-related practices current in Nepal. "They give more emphasis on *ghee*, sugar, soups. That's the typical. And this *sutki masala*... There's a lot of fat food, oil massages and there is a fireplace, and she is given as much warmth as possible – both the mother and the baby. Yeah, those are the typical things that they [Nepalis] do after the birth". While openly doubtful about aspects of the food-related practices – "I don't think that eating that much fat is good because even a thin lady becomes fat lady after she has given birth" – Prithi had gone on to explain that they were done because "they [Nepalis] feel that after giving birth the woman becomes very weak physically, so in order to give them more strength, the more fat is nutritious, not nutritious [Prithi corrected her own use of the word here] more like fat and sugary things that make her strong and oil massages will make her body strong". Sitting next to her on the sofa, Prithi's husband had then added: "I would encourage women to eat less after they give birth to children because I want them to be in form". I had felt compelled by this comment to ask Prithi if becoming a little bigger was a concern for the women. She thought not, her answer reflecting an apparent inevitability about the situation: "It's not a concern with the women. It might be a concern with the men [laughing]. Because it's obvious like... it is expected that the mother would gain a lot of weight after the birth, because she would be pushed with nutrition and she has to because she can't avoid it, because of the pressure from the rest of the family members.

And it's obvious that she will gain weight [laughs]. I have never seen a mother after giving birth to a baby that has maintained the same figure, even the thinner, most thin girl has arising this fat.”

Advice for new mothers on their eating habits postnatally

Several of the women I spoke with remembered getting advice and leaflets from midwives or other medical personnel about breastfeeding, bathing and aspects of care related particularly to the newborn baby. However, amongst almost everyone I talked to on the topic, none had experienced the medical staff paying attention to the new mother's diet. Where this had happened, for example in Sonya's case, the reason was motivated by the child's health (her daughter's loose stools) rather than any particular concern for Sonya's own state. She, herself, had expressed her surprise at this, describing it as “very strange” how in Norway both during previous experiences of illness as well as, in hospital, following her daughter's birth, from doctors “I never got advice on what to eat”. This she contrasted with Nepal where “if you ask the doctor I think they would suggest [something to] you”. Friends and family, meanwhile, served as a ready source of tips and advice for my Nepali respondents regarding what they should (or should not) eat while breastfeeding. The ideal of avoiding ‘cooling’ food and cold drinks was known and mentioned by many but, as most admitted, impossible to follow strictly in Norwegian daily life and so they did not try to. Otherwise, in addition to spices, the eating of which most women limited significantly in the first few months, some women were also advised to avoid certain other foods thought to cause colicky-type problems for the baby, principally chickpeas, cabbage and, in one case, onions.

Compared with the attention given over to feeding the new mother to ensure *her* own wellbeing that the Nepalis I worked with demonstrated, emphasis on maternal diet so as to benefit the infant was notably less. Of course the widely-known appreciation of *jwano*'s breastmilk-enhancing qualities is clear from the above accounts, yet aside from the mild (and variable) caution exercised around spices and possible colic-inducing foodstuffs, for my Nepali respondents the mother's health was the main focus of dietary concern. Therefore, we arrive again at the second main point this chapter makes: the valuing by the Nepalis I met of the mother in her own right, and foregrounding of her own health in the few weeks and months after having given birth. The significance of this finding is clear when contrasted with those of the previous chapter. There, as we have seen, postnatally (as well as in pregnancy) official Norwegian food-related guidance is shown to place much greater weight on how the maternal diet provides appropriate nourishment to the child (Helsedirektorat 2011a; Matportalen 2011c). A ‘medicine as food’ model predicated upon a nutrition-based account of food, moreover, is clearly outlined, wherein the role stressed is that of the individual mother as wholly responsible

for consuming foods that contain nutrients her child needs. An individualised notion of the mother is thus asserted even if it is then subsequently elided by the overwhelming focus on the child. All this stands in opposition to the more socially-accountable understanding of collective responsibility for the new mother and child expressed by so many of the Nepalis I worked with, further underscoring this chapter's first main contention regarding the importance for them of social relations in ensuring maternal wellbeing. And taken together, these contribute to the third key argument of this thesis: the need to recognise my Nepali respondents' prizing of maternal wellbeing and the sense of collective responsibility therein, which exists in considerable contrast to the prevailing biomedical approach and rhetoric of their host country.

Discussion

As already discussed in Chapter 4, reference to and a theoretical appreciation of the food as having 'hot' or 'cold' qualities in line with Ayurvedic, humoral accounts of health cropped up during several exchanges with the Nepalis I got to know. Here I have also described some evidence of it within their food practices during pregnancy and postnatally, yet also noting how, as with life in general, the extent to which expectant or new mothers acted upon these varied according to individuals and situations. Furthermore, exposure to other epistemologies, biomedicine for example, whether in Norway or Nepal, may have tempered my respondents' 'hot'/'cold' related food practices – or accounts of them (recalling the explanation for *jwano*'s efficacy residing in its high calcium concentration). Nonetheless, my findings share notable similarities with existing anthropological research that describes how ante- and postnatal foodways incorporating 'hot'/'cold' health beliefs continued to be observed by immigrants from the Middle East, South Asia and China following migration to the UK (Bradby 1997; Harbottle 2004; Homans 1983; Wheeler & Tan 1983). For Punjabi women living in Glasgow, for example, pregnancy was often considered a 'hot' state, requiring proscription of 'heating' foods (eggs, for example) throughout, although most particularly in the early months when it was perceived that excess heat could trigger a miscarriage (Homans 1983: 75). Following birth the woman's body was, in contrast, considered excessively 'cool' (ibid.) 'Warming' and 'hot' foods were thus advised and 'cooling' or 'cold' ones, such as many dairy products and green vegetables, counselled to be avoided (ibid: 76). Work with middle-class Bengali women in Kolkata (formerly Calcutta), meanwhile, found food taboos to be an oft-mentioned aspect of pregnancy, yet little consistency between accounts was demonstrated (Donner 2008b).

Donner's (2008b) research, although not done in a diasporic setting, is instructive for yielding further insights into the way that, in a South Asian context, various social relations can influence what women eat during pregnancy. As with Sonam and Sasmita's experiences, in Kolkata too residence following marriage was usually virilocal, and the mother-in-law

frequently played a pivotal role in determining a pregnant woman's diet, as well as their movements and exposure to unrelated persons (ibid: 105). The particular, normative household structures and power relations in Kolkata that played such an integral role in shaping the behaviours of their occupants, were – as already highlighted – not the case in among the Nepalis living in Norway that I got to know. That said, similar patterns were noted to persist in South Asian groups following immigration to the UK, in cases where mothers- and daughters-in-law live in close proximity (although not necessarily in the same household) (Homans 1983: 78). Yet even if such patterns were not so present among my Nepali respondents, I would argue that the importance of social relations in helping at least to inform ante- and postnatal food choices was. As we have seen, Nepali family, friends and sometimes even relative strangers would seek to provide particular *sutki* foods for a new mother. For a pregnant woman, meanwhile, advice from friends and relations, some of it based on Ayurvedic, humoral logics, whether heeded or not, was readily available and given. In this way, the relevance of the larger social and cultural milieu to understanding any ante- and postnatal food choices a Nepali woman living in Norway might make is clear. And even though it may be the dominant medical framework active within the country she now lives, applying a purely biomedical lens to this Nepali woman and her dietary habits and practices, treating her as an individual patient, ignores the fact that she is a person tangled up in various relational webs that can also shape what she might do as well as how she might feel. This complex configuration and interrelation of social, cultural and medical factors applies, I would contend, to all of us – not just Nepali immigrants to Norway. Accordingly, looking beyond hegemonic models and discourses such as biomedicine, as this thesis does (and according to its second key argument), is crucial I would suggest, if we are to understand better foodways in relation to health and wellbeing, whether during pregnancy and postnatally or more generally.

The lack of being able to recall in much detail any of the official antenatal (and postnatal) dietary-related information was, as has been shown, something I found common among the Nepali women I spoke with. The issue of language is clearly a significant one: if most of the published information appeared only in Norwegian, how accessible (and therefore accessed) or relevant could it be to those who did not speak the language? Although none of them explicitly mentioned this as a problem, it is one of the reasons I would speculate as to why the Nepalis I met with made little mention of written ante- or postnatal guidelines having been important in their experiences. However, I would argue that the text- (and web-) based information detailed in the previous chapter, written and endorsed by the state and promulgated by health personnel (as direct employees of the state), give us a clear indication of the prevailing philosophy used when considering the dietary needs of pregnant women and new mothers in Norway. And,

therefore, the Nepalis I spoke with would have encountered this, one way or another, during their dealings with the health services.

Nonetheless, beyond vitamin D and folate supplementation, and for some the avoidance of seafood and soft cheese, the women had little to say about formal (bio)medical antenatal dietary advice they had received. Given that several Nepalis I met commented on the existence of numerous food ‘rules’ practised in Nepal, many incorporating alternative medical understandings (principally the ‘hot’/‘cold’ dichotomy), there was plenty of scope for women to include these instead. And, as discussed, this has been the case for other diaspora communities holding similar understandings (Bradby 1997; Harbottle 2004; Homans 1983; Wheeler & Tan 1983). However, beyond a few instances, and as the discussions at Indira’s gathering showed particularly well, any practices or proscriptions were variable (echoing Donner’s (2008b) findings), and the number actually adhered to few. More than anything, the impression gained throughout fieldwork was that Nepali women changed very little about their diet when they became pregnant. They took the medically-advised supplements, listened to friends and family’s advice (although not necessarily heeding it), perhaps consulted the internet although not usually about dietary matters, and otherwise seemed to follow their instincts.

This more instinctive approach took an interesting turn in Nirmala’s story, where, upon learning that her baby was not growing as much as expected, she had actually ignored specific medical advice (to keep her sugar intake low on account of possible diabetes). Worried that her son was “not getting all the nutrition he should get”, she had resolved to no longer restrict anything, regardless of the possible consequences to her own health. And although she came to regret her decision, I find it a useful moment to reflect on the role of biomedical input and its assumed priority over other positions or views. While I would in no way attempt to assert that Nirmala’s instinct or decisions enacted any particularly Nepali way of regarding pregnancy, it points to the possibility of women making and acting upon alternative (i.e. non-biomedical) assessments of the situation, potentially valid albeit within other frames of reference. This again relates directly to the second key argument presented in this thesis: that to better understand and appreciate the complexity and nuances of people’s foodways in relation to health and wellbeing requires that we look beyond biomedical models, however dominant they may be within a given setting. Furthermore, Nirmala’s experience also speaks to the fourth key argument of this work, in suggesting a limit to the state’s authority, at least in her eyes. Whether or not Nirmala did the ‘right’ thing is not at issue here. What is, is that her reasoning and actions provide a powerful example of how, within the context of pregnancy, biomedical advice can be, and is, actively disagreed with – even when it might be considered especially compelling (Nirmala’s risk of developing diabetes) and backed by significant infrastructure (the intensive monitoring of her

pregnancy by the Norwegian medical system). Nirmala clearly understood the biomedically-defined risks of her actions (“I’m not going to control it, it doesn’t matter if I have sugar [her reference to diabetes], I’m eating”), but chose an alternative route; her negotiation of the situation seemed instead to draw more on embodied notions of what needed to be done. Thus, while there is no indication that she turned to a particular alternative set of medical ideas (Ayurvedic, for example) the situation hints at the contingent nature of biomedicine despite its apparent hegemonic status in Norway as well as significant presence in Nepal. While a very particular example in this case, Nirmala’s example resonates with the instances described earlier that highlight the difference in emphasis given to postnatal diet by Nepalis as compared with the Norwegian state health authorities, and to which I will return a little further on.

Power relations are also a question within immigrant patients’ encounters with biomedical personnel and practices. As mentioned in Chapter 3, immigrants to Norway were often seen to be at a disadvantage when interacting with state medical services (Fagerli et al 2005). Yet the aforementioned examples suggest that the Nepalis I encountered were not unduly cowed or influenced by biomedical authority as presented in those settings (or, given their lack of recall about it, via any published guidance). In other words they seemed to be less subject to power-related dynamics. Why not? Because, I would contend, they were the product of a particular background: educated, middle class (in Nepal, as well as in Norway) and therefore potentially more confident in their own opinions and authority in the face of others. Again this clearly ties into the thesis’ fourth key argument concerning the perceived limitations to the authority of Norwegian public health claims.

Coming back to the matter of guidance regarding ante- and postnatal foodways, Padma’s husband, Krishna, offered an interesting perspective on the degree to which, in Nepal, advice was given to pregnant women. While acknowledging that “there are so many things in Nepal they say ‘don’t eat’ when you are pregnant”, he went on to suggest this was limited to urban centres, a consequence of development: “In Nepal you know, only in Kathmandu do they say ‘don’t [eat]’. I mean people who are in the developed city, in the city area, they care about those kind of things. But where I came from, my Mum used to carry, you know, like normal things, was used to carrying heavy stuff when you go to the village – wood, grass. They are used to doing normal things... Because they have to.” Here, I think, aspects of the middleclassness described by Liechty (2003) and Donner (2011) and discussed in Chapter 2 are reflected: biomedical input, itself a signifier of modernity, conferring ‘modern’, urban, middle-class status on those who actively seek it out. Sonam and Sasmita’s comments when at Indira’s place echoed Krishna’s comments to some degree. Married and hence living with their husband’s family, it was their mother-in-law who decided what the household ate. Hence, in what they and

Krishna described, their lack of choice back in Nepal was simply a matter of practical necessity. This is in line with what Donner (2008b) described in Kolkata, and was also the case for some Punjabi women living in Glasgow (Homans 1983).

The importance of social relations in maternal care for my Nepali respondents was the first of the three central themes of this chapter. As already stated, however, any obvious influences of mothers or mothers-in-law seemed to be attenuated by these Oslo- and Ås-based families living in nuclear groupings, the virilocal living arrangements of Nepal no longer pertaining. The effects of this are seen, for example, in Jyoti easily ignoring her mother's advice both to eat more during her pregnancy and to have *sutki masala* following the birth of her second son. That said, visits from parents and parents-in-law of several months' duration were common, so there were periods of time when the older generations' norms and values regarding foodways could be expressed. Yet as they were not in their own homes, in a foreign country and unable to speak the local language, they remained reliant on their children in ways that further limited their influence.

The influence of other members of the family (especially mother-in-laws) can often be construed as interfering and negative. However, as shown, the Nepalis (as well as Ida, married to a Nepali), who had received such visits from their older relations spoke of the experiences warmly, welcoming the additional assistance, not least the regular preparation of *sutki* meals. Evident from the examples described above is that what a new mother eats is of concern to more than just the individual herself, her family and friends share and partake in the responsibility. The health and wellbeing of a new mother is regarded as a collective endeavour, with *sutki*-appropriate food a central part of this: husbands do their best to make it (and lament its lack in Norwegian hospitals); family come to stay and prepare it; friends deliver meals of it; ingredients are posted. This is in marked contrast to the highly individualised accounts of maternity so evident in Norwegian public health discourse (see Chapter 5), which while acknowledging the importance of support from surrounding family and friends, nevertheless locate responsibility for the new mother's diet and nutrition firmly within the individual herself.

The second main argument made in this chapter, that the Nepalis I worked with paid significantly more attention to a maternal wellbeing (within that focusing much more on a mother's postnatal diet than the antenatal one) compared with the official Norwegian biomedical approach, is by now quite obvious. Furthermore, consistently expressed by all the Nepalis I spoke with, was the importance attached to a new mother eating *jwano*-infused meals and *sutki masala* (or a near equivalent, as in Sonya and Maya's cases). These particular foodways seemed to endure in Norway even where others were no longer adhered to. As already

mentioned, the proscriptions on consuming cold drinks and food following childbirth, usual in Nepal, had to be disregarded in Norwegian hospital settings. A matter of practical accommodation on the part of the Nepali women to the different food practices of the Scandinavian nation, where iced drinks and bread are considered normal, and entirely acceptable foodstuffs in a postpartum setting. That said, the accounts of Annie, Sonya and Mira in particular reflect their obvious relief at having been able to receive warm meals of rice, soups, *dals* etc. – “proper *sutkeri* food” as Mira had described it.

That Norwegian health authorities would regard *sutkeri masala* as ‘proper postnatal food’ is unlikely, given their explicit warnings to new mothers not to eat too many sweet or fatty foods (see Chapter 5). Here we confront a clear divergence in perceptions of what is ‘healthy’ for a woman in the postnatal period. As already shown, the nutritionism of formal Norwegian biomedical advice is carried through from pregnancy, women expected to simply eat healthily in accordance with this (Chapter 5). In contrast, the Nepalis I spoke with asserted that the postnatal period was exactly the time when a woman needed rich, strengthening foods, to enable her to recover her physical powers, to ‘tighten’ her loosened body and to provide abundant breast-milk. This speaks to an alternative, non-biomedical vision of the woman’s body, one where fat and sugar are not merely ‘poor’ sources of calories, but, rather, valuable and valued substances that as part of certain foods are capable of restoring the new mother’s body to health. This again foregrounds the contingency of a biomedical account of foodways as well as demonstrating the value of questioning its dominance or claims to ‘truth’. The Nepalis I encountered, while very aware of biomedical accounts and logics, abiding by them in many cases, showed how they ensured maternal wellbeing through drawing on different understandings of what was healthy.

That said, Jyoti’s efforts to avoid “fatty things” following her second pregnancy, Ida’s husband’s comments about his “health conscious” Nepali family and Nirmala’s description of *sutkeri masala* as a “calorie bomb” point to a plain acknowledgement by my respondents of how, in biomedical terms, *sutkeri* foods might be considered unhealthy. Nayan, Maya’s husband and a doctor, articulated this view very clearly. Making plain his belief in “scientific explanations” and “evidence-based findings” as the grounds upon which he knew what was “true”, he went on to describe the “uncritical attitude” he considered typical of most Nepalis (his wife included – she was sitting opposite him at the time) to certain food-related habits and practices, which as a result “they just follow”. Attributing this lack of questioning to lower educational levels, he went onto assert that the increased levels of *ghee* and sugar traditional as part of *sutkeri* food were “unnecessary – so much sugar and fat would only make them fat, especially as they would not be moving around very much”. Prithi’s husband, also a doctor,

voiced similar concerns although his particular comments seemed to relate more to the woman's shape than their health. Interestingly, despite Nayan's own opinions, it did not appear to stop his wife from eating the *sutki* foods that she did. Moreover, like Ravi (also a doctor), he did endorse *jwano*, thinking it "actually worked" in assisting milk production, reiterating the point that because of Maya's overproduction of milk she had had to actively avoid it.

Despite these more biomedical nutrition-based concerns, the importance of a new mother having *sutki*-type foods for at least some period after the birth was significant to the Nepalis I spoke with in Norway. The 'emergency *ghee*' vignette that opens this thesis was a prime example of how seriously and collectively the Nepalis I encountered seemed to take the postnatal period. Annie, who, as mentioned above, had asserted her nursing training made her more sceptical about many Nepali food practices and proscriptions surrounding pregnancy, had nevertheless sent a significant quantity of *ghee* (and *jwano*) to a Nepali woman she did not know well, living in distant Norwegian city, on hearing that the expected provision of these foodstuffs (from Nepal) had not arrived.

As discussed in Chapter 3, *ghee* – a key component within the culinary cultural practices of India, Pakistan and Nepal – is regarded within Norwegian public health and biomedical discourses in fairly negative terms (Mellin-Olsen & Wandel 2005; Wandel et al. 2008). As a fat it is calorific, but moreover contains a high degree of the 'wrong sort' of fat, namely saturated fats, consumption of which in large quantities has been implicated in the aetiology of cardiovascular disease as well as obesity, which in turn is linked to diabetes. And public health research shows that cardiovascular disease and diabetes are conditions that South Asians, especially those who migrate to higher income regions, become particularly susceptible to developing. Dietary guidance and advice in Norway, directed towards immigrants (SEF 2002) but also more generally (for example, Matportalen 2011d) and antenatally (see, for example: Hay 2014; Helsedirektorat 2009; Matportalen 2011b), suggests limiting use of *ghee* and butter, and instead focus more on plant-based oils (rapeseed, sunflower, olive). As the preceding chapter showed, Norwegian public health and biomedical attention to postnatal foodways seems to be limited by-and-large to matters relating directly to breastfeeding, but I would argue it is reasonable to assume that the general advice about 'healthy eating' pertains. Therefore, overall, if one takes the above-described *sutki* meals as forms of advice in action, a sharp distinction is revealed between the formal biomedical position (as detailed in the previous chapter) and the approach and input of Nepali family/friends with regard to the foodways of women who had recently given birth.

Finally, I return to the third main argument of this chapter: how the background and experiences of the Nepalis I encountered placed apparent limits on the authority they gave to official biomedical accounts of pregnancy and post-partum period as articulated in Norway. Here I would contend that my Nepali respondents interacted with the Norwegian state in a considered, agentive way. As the accounts of Nirmala, Rita and others have shown, they demonstrated a conscious appreciation and negotiation of what the state in Norway offered them, in terms of biomedical advice as well as financial support. They accepted what suited them – access to free medical care before, during and after birth; parental leave allowances and payments – while not seeming to engage particularly heavily, if lack of memory is a valid measure, in the food-related advice made widely available to them. And, in Nirmala’s case, actively opposed the guidance when she thought her son’s development was being harmed. This balanced approach to state intervention may reflect aspects of the way that the Nepalis were more used to experiencing government. At the time I was carrying out fieldwork, the Nepali state remained in quite some disarray, following the preceding civil war; although peace had been restored in 2006 and a fresh constituent assembly subsequently formed, a new permanent constitution had yet to be agreed upon (this would finally happen in September 2015) (Mocko & Penjore 2016). As noted in Chapter 2, politics was a popular topic among many of the Nepalis I encountered and although now living in Norway, most had experience of living in Nepal and nearly all visited there regularly. The term “corrupt” was applied frequently to Nepali politicians and Nepali politics if the subject came up, and although Norway was often cited as the positive example in comparison, it points to the potential for Nepalis to hold more circumspect views of any state as an entirely reliable or authoritative structure. On the other hand, there are reasons to suggest Nepalis would be willing subjects of the Norwegian state. Possible signs of this included their faith in the relatively more stable Norwegian government and infrastructure (with respect to food hygiene standards, for instance – see Chapters 3 and 4), and use by most of biomedical explanations, advice and input in keeping with a middle-class identification as urban and modern (see Chapter 2). In ante- and postnatal matters, the overall impression I gained however was that the Nepalis engaged with the Norwegian state in ways that suited them, the Nepalis, best.

Conclusion

Based on all the of above, I would argue that among the Nepalis I worked with, the women’s relatively relaxed approach to their diets during pregnancy, the significance of what they ate in the postnatal period, and the engagement of family and friends in ensuring that, indicated a notable prizing of the woman herself within the process. In the antenatal period, her own judgement on what she did or did not eat was valued. And in the postnatal period, her own health – and not just that of the newborn – was explicitly recognised, attended to through the

provision of specific, good-tasting, strengthening and nourishing *sutki* foods, provided by those in her family but also by the wider Nepali community. This attention paid to the woman's care, moreover, was an indication I would argue of a more collective sense of responsibility for her wellbeing. In contrast, the overriding concerns of the Norwegian health authorities and recent public health research, presented in the previous chapter, stress the individual responsibility of the mother and privileging of the child, both during pregnancy as well as following birth. All this relates directly to the first two main points made in this chapter – the significance of social relations during both pregnancy and postnatally for the Nepalis I worked with, and their prominent valuing of maternal health within this. Yet it also forms the basis for the third main argument of this thesis. That is, that my Nepalis' respondents' collective approach to foodways and maternal care during pregnancy and especially postnatally serve as a notable rejoinder to the Norwegian state and public health position, which focuses heavily on the antenatal period and more generally overemphasises the individual mother and her responsibility all within a highly biomedicalised account.

I would also suggest that my respondents related to the Norwegian state, through its emphases and expectations of its subjects' behaviour regarding pregnancy and postnatal foodways, in a considered, personalised way. On the one hand, confident in Norwegian food standards, they felt they could be relatively easygoing about what they ate antenatally; they were also ready recipients of medical care and welfare support. Both reflect their greater faith in the trustworthiness, quality and robustness of Norwegian state infrastructure. On the other hand, they seemed not to pay that much heed to the specific antenatal and postnatal foodways-related guidance, instead following their instincts (in Nirmala's case) and postnatal practices more usual in Nepal (*sutki masala* and *ghee*, for example). While this did not, I believe, amount to a conscious disregard for their host nation's advice, it indicated an assuredness among the Nepalis of what was relevant to them that may relate at least in part to their self-identification as being both well-educated and middle class, and hence sophisticated consumers of medical information. In addition, it could also connote a healthy limit to perceptions of the state's authority that might or might not be attributable to their experiences of the governing of Nepal. Taken together, these particular readings speak to this chapter's third main point – the bearing that my Nepali respondents' particular class- and experience-based background had on their interactions with state-endorsed diet-related health information and services. They also add further weight to the second and fourth key arguments of the thesis: my findings from working with Nepalis living in Ås and Oslo highlighting the contingency of biomedical hegemony surrounding dietary advice, as well as its claims for authority in Norway – be it in relation to maternity or health and wellbeing more generally.

Having now presented my research findings, the analyses and interpretations from this and the previous four chapters are drawn together in the next and final chapter, where future, related lines of enquiry are also suggested.

Chapter 7 – Conclusions

Returning to the ‘emergency *ghee*’ story that begun this thesis, we can now see how the intervening chapters serve to inform and illuminate specific elements within that vignette. The incident described two South Asian women in diaspora, both Nepali, both living in Norway and both middle class – in Nepal, as well as in Norway, their biomedical training and subsequent work (one as a nurse, the other a doctor) attesting to this. The women’s biomedical training, moreover, meant that they were well-versed in accounts of foods and foodways predicated upon nutrition-based logics and no doubt fully aware of *ghee*’s less-than-positive profile within that paradigm. Moreover, they would have known that as South Asians, they were deemed particularly ‘at risk’ of harm from a high intake of fats such as *ghee*. Nevertheless, upon hearing that a pre-arranged order of *ghee* from Nepal had not yet arrived, and despite not knowing the woman doctor at all well, the nurse, Annie, went to significant lengths to make sure that the foodstuff was made available to her fellow Nepali, because she was a new mother. In this case, *ghee*’s necessity as an ingredient considered both ‘warming’ and strengthening was governed by appeal to an alternative Ayurvedic, humoral medical system.

This example, moreover, effectively encapsulates the second, third and fourth key arguments of this thesis, which were first outlined in the introduction and have been alluded to subsequently at points throughout. With regard to my second argument, the actions of Annie the nurse (and action of the Tromsø-based doctor in originally ordering *ghee* from Nepal) show how the Nepalis I worked with could (and did) utilise other medical frameworks, in addition to biomedicine, when making connections between what they ate and consequent feelings of wellbeing. This runs counter to, and suggests a need to look beyond, the hegemony of biomedical models and conceptions of foodways in relation to health, pregnancy and postnatal care in Norway. Meanwhile, the earnestness with which Annie acted in response to her fellow Nepali’s situation exemplifies how seriously the Nepalis I encountered took the diet of a new mother, and underlines the way postnatal care was considered a collective enterprise. This therefore speaks directly to my third argument: the marked propensity of Norwegian public health and state-endorsed maternal health-related dietary guidance to place responsibility for maternal and child health squarely with each individual mother, therein focusing on the individual mother’s health almost exclusively in relation to the newborn child (and prior to that in service to the child-to-be). And yet, conversely, findings from my work with the Nepalis in Oslo and Ås show the need to recognise alternative approaches such as the mother-focused, collective one demonstrated by my Nepali respondents. Finally, that the two Nepali women found alternative authority based on Ayurvedic-inspired understandings of food for their actions

also shows a selective engagement with a Norwegian state that promotes a highly biomedicalised account of diet and wellbeing. In this way their actions neatly illustrate my fourth major argument: the limitations of the Norwegian state's authority in relation to advice on health more generally.

The key arguments are returned to a little further below (each after all relating to more than simply the 'emergency *ghee*' incident). In order to better contextualise them, however, while at the same time demonstrating the arc of this research, a brief synopsis of the major findings now follows.

Summarising the findings

In this thesis I set out to analyse how the dietary habits and practices of Nepalis living in Ås and Oslo related to their perceptions of health and wellbeing. Therein, I have paid particular attention to pregnancy and the postnatal period. As Chapter 2 has shown, although they have been present for several decades, the Nepali population in Norway remains relatively small (albeit growing). Unlike the Pakistanis who initially came to fill gaps in the manual workforce, or the Sri Lankan Tamils who arrived as refugees, the overwhelming reason the Nepalis I worked with came to Norway, at least in the first instance, was to pursue further higher-educational study. Most came from urban areas of Nepal, where they not only had finished school but also often gained undergraduate as well as postgraduate qualifications. They self-identified as middle class, and on arrival in Norway seemed to be able to integrate quite easily into the broad Norwegian middle class. Establishing the middleclassness of the Nepalis I worked with is salient to this thesis not only for differentiating them from other 'South Asian' immigrants, but in partially accounting for their relatively smooth adaptation to certain Norwegian norms surrounding foodways.

The next chapter (Chapter 3) provides a critical discussion and analysis of public health literature on South Asians living mainly in and around Oslo. It details how how existing Norwegian public health research attitudes apply a biomedical frame that not only 'lumps together' highly diverse South Asian people, but then readily attributes 'unhealthy' practices within the group to 'culture'. In attempting to address this, the researchers are shown seeking to gain knowledge of this cultural information, often presented on their part as an act of demystification or 'code cracking'. Their aim appears to be to then reinterpret the information in terms of nutrition, which allows the cultural practice(s) to be directly related to the current, local biomedical concerns surrounding South Asian immigrants, namely diabetes and cardiovascular disease. Thus instrumentalised and newly reconfigured, this cultural knowledge can, moreover be disseminated back to the relevant immigrant groups, preferably via 'channels' themselves

identified by public health researchers as optimal for their biomedical ends. Chapter 3 also sets the scene for Chapters 4 and 6, as a way of contextualising the public health climate in which my Nepali respondents lived, and which, as shown, could potentially shape and impinge upon their lives.

Chapter 4 explores and interprets the various ways in which the Nepalis I encountered living in Norway related their foodways to health and wellbeing. Demonstrated here are how these Nepalis adopted their host country's timings and content for breakfasts and lunches in particular, expressed an apparently laid-back attitude to their children's development of preferences for more Norwegian-style foods, and regularly espoused biomedically-based nutrition discourse when relating food to health and wellbeing. However, also made clear are the ways in which my respondents utilised non-biomedical metrics when reasoning about foods in relation to health. The 'hot'/'cold' dichotomy was a common, if inconsistently applied, point of reference, as were notions of the relative digestibility and 'heaviness' of foods. That the Nepali I encountered adopted some new foodways yet not others, as well as their variable application of biomedical yet also Ayurvedic-inspired understandings of diet in relation to health, could, moreover, be described as 'bricolage' (Lévi-Strauss 1972): the Nepalis I met drew on specific structures within their realms of knowledge and experience, yet in an improvised way, creating a composite approach that incorporated both 'traditional' and 'modern' elements. The importance of food tasting 'good' and giving satisfaction, most often through judicious application of spices was also a common theme, and something that my respondents used to differentiate what they ate from Norwegian and other Western foods, which many characterised as bland. Furthermore, a sense of the value of commensality to physical as well as social wellbeing was something that some of the Nepalis I spoke with were keen to stress.

From considering foodways in relation to health more generally, attention then turns more specifically to dietary habits and practices in pregnancy and postnatally. Looking first at the Norwegian state-endorsed guidance and public health research, Chapter 5 delineates an approach that again remains tightly bound to a biomedical account of food. Within this, the focus is heavily geared towards the antenatal period; almost all maternal dietary advice in the postnatal period, meanwhile, is directed towards enabling and enhancing breastfeeding as well as trying to encourage 'healthy eating' and avoidance of further weight gain in the mother. More generally, the emphasis throughout all the sources I reviewed was on the health of the child, and overall an individualised notion of (maternal) responsibility for health was assumed – both for the child and for the mother. Alongside this was the presentation as 'normal' of a Norwegian-style diet comprising foodstuffs deemed 'healthy' according to biomedical standards. Together, this individualised, biomedically normative account also encoded notions

of morality and self-regulation (Coveney 2006; Foucault 1991a; Middelthon 2009) within the guidance and research. As with Chapter 3, Chapter 5 again serves to lay the ground for my ethnographic findings detailed in Chapter 6, in so doing providing a context against which the latter chapter's findings can be read.

Chapter 6 thus describes and interprets what I learned about the ante- and postnatal foodways of Nepalis living in Oslo and Ås. As educated, middle class citizens, it became clear that my respondents readily availed themselves of the biomedical care (check-ups, hospital-based births) as well as welfare support (paid parental leave) on offer in Norway. Yet at the same time, in discerning their relative lack of engagement with the (extensive) official dietary guidance available in Norway and generally quite relaxed attitude towards eating habits during pregnancy, the alternative emphases the Nepalis applied surrounding maternity-related foodways emerged. Most obvious was the attention paid to the postnatal period and maternal wellbeing within that. Therein, a notable valuing of the woman herself within the process was evident, and social relations appeared to be central: the mother regarded as more than simply an individual biomedical patient, but rather a specific kind of person with specific relational ties. The particular *sutkeri* foods prepared by friends and relations were given, according to humoral understandings of health, mainly to aid the new mother's post-birth recovery and enhance her wellbeing. While certain key ingredients (*jwano*) were intended to ensure effective breastfeeding and hence benefit the infant, other foods such as *ghee*, nuts and spices were primarily to restore the mother. And the responsibility for providing this non-biomedically-defined nourishment was a collective one – husbands, parents and parents-in-law, as well as friends and mere acquaintances even (as in the 'emergency *ghee*' incident), acting to make sure that Nepali women living in Norway were well-enough cared for in the postnatal period.

Consequently, three main analytical points arise in this chapter. Firstly, there is the clear importance of social relations both during pregnancy and postnatally for the Nepalis I worked with. Secondly, that within these periods, the health and wellbeing of the mother seemed to be foregrounded much more by my respondents than it was by the Norwegian biomedical maternity-related resources. And thirdly, I would suggest that the specific class- and experience-based backgrounds of the Nepalis I encountered could have had a bearing on how they interacted with state-endorsed pregnancy and postnatal guidance and services. Combined, these first two analytical points also form the basis for the third key argument of this thesis, while the third point adds weight both to the second and fourth key arguments. And it is to these four key contentions, which together underpin this study, that we now return.

The key arguments revisited

Initially presented in the introduction (Chapter 1) yet referred to where pertinent in subsequent chapters, here the findings of the thesis are drawn upon to consolidate as well as reiterate the value and relevance of my four key arguments.

Regarding the first main contention – the need to disaggregate the ‘South Asian’ category and centrality of my respondents’ middleclassness in exposing this – we can now see how inaccurately homogenising the overarching formulation ‘South Asian’ can be. As Chapter 2 shows, the different circumstances for migration, as well as original geographic, educational and especially class backgrounds between Pakistanis and Nepalis now living in Norway, already point up the classification ‘South Asian’ as unwieldy and overgeneralising.

Subsequently, the detailed analyses of Nepali foodways in relation to general (Chapter 4) and maternal health and wellbeing (Chapter 6) delineates how the ready use of ‘South Asian’ by public health specialists in Norway (Chapters 3) may lead to the effacement of significant differences between – as well as potentially within – what can be pronouncedly heterogeneous groups. My research has, for example, identified some specific contrasts between the foodways of the Nepalis I worked with (as well as perceptions thereof) and those of Pakistanis living in Oslo. At the same time, the category of ‘South Asian’ enables simplistic ascription of motivations for certain foodways (the consumption of *ghee* being a ‘cultural practice’, for example), and the assumption that particular dietary habits and practices deemed ‘unhealthy’ according to biomedical accounts of nutrition can be resolved through more (nutritional) education. As my findings make clear, the Nepalis I worked with, who were middle class and many highly-educated, were well aware of biomedical evaluations of food, yet made their food-related choices by drawing on more than just this paradigm.

Which brings us to my second main argument, so clearly evident in both Chapters 3 and 5: the dominance, in Norway, of biomedical models of nutrition in relation to health as well as pregnancy and postnatal wellbeing. However, the ethnographic accounts detailed in Chapters 4 and 6 make plain the often sophisticated balancing of biomedical understanding with other (usually humorally-inspired) evaluations of health that the Nepalis I encountered demonstrated, as well as the variation between respondents in how and when they might prefer one approach over another. This more nuanced view of foodways as well as notions of health and wellbeing that my anthropological approach reveals also highlights the (problematic) perceptions of, and instrumentalist approach towards, ‘culture’ evident within Norwegian public health discourse. Taken altogether, it shows just how narrow a purely biomedical reading of nutrition can be. Based on these findings, I therefore assert a very real need to recognise not only the dynamic but also sometimes subtle, individualised and even inconsistent movements between various

medical paradigms that the Nepalis (and no doubt, people in general) make in their efforts to achieve health and wellbeing.

The third key contention, outlined in Chapter 5, is the strong tendency of Norwegian state-endorsed ante- and postnatal dietary guidance as well as public health research to overprivilege the individual mother's responsibility for her own health in service to the coming or newly-born child. This is at the expense of potentially alternative distributions of responsibility for, as well as emphasis on, the wellbeing of both offspring *and* mother. Furthermore, within the Norwegian literature a rhetoric of 'normalisation' (Foucault 1991b) is shown to permeate the official literature, presenting foodways that correspond both to biomedical definitions of 'health' (within which a notion of 'medicine as food' is apparent) yet also to typically Norwegian patterns of eating as appropriate. Therein a certain moral weight is also shown to be ascribed to the individual's food choices: 'healthy' food as positive; 'unhealthy' food, negative (Coveney 2006; Middelthon 2009). Again my own ethnographic findings challenge these positions. In Chapter 6 the numerous accounts given by the Nepalis I encountered detail the care and effort directed towards the nourishment of the mother post-partum, often delivered as a collective response from friends and family and incorporating certain typically Nepali food-related habits and practices. Furthermore, they reported giving relatively scant attention to maternal dietary habits and practices during pregnancy (including to any official guidance). As already stated, these were middle-class, well-educated people, who appeared confident in applying their own knowledge and experience of biomedicine as well as understandings based on Ayurvedic, humoral-based logics when deciding upon ante- and postnatal diet: they thus engaged with state guidance in a consciously selective way. Accordingly, I would argue that my respondents' food-related maternal health practices serve as a notable counter to the Norwegian state and public health approach. The Nepalis I worked with demonstrated an important, alternative way of considering pregnancy and the initial period after birth. Their focus on the mother and treatment of ante- and especially postnatal care as a collective enterprise, relationally shaped, not only merits greater appreciation and understanding on its own terms but also acts to challenge the highly-individualised, normative account promulgated by state-endorsed Norwegian public health research and guidance.

Finally, the fourth key argument – limitations to the perceived authority of Norwegian state advice on health in general – is addressed in relation to my respondents in both Chapters 4 and 6. Although such official guidance is often presented as somehow self-evidently or fundamentally true and therefore 'only reasonable' to follow, we have seen how the Nepalis I worked with – highly educated and well-informed – chose at times to draw on other resources and sources of authority embedded within networks of Nepali friends and relatives, most living

in Norway but some also in Nepal. This is perhaps most clearly visible in their use of certain aspects of the biomedical maternity services available to them, yet relative non-engagement with official Norwegian guidance on diet during pregnancy (and instead focus on maternal foodways after the birth and appeal to an alternate medical framework within that). It suggests a measured, agentive approach: their middleclassness and education informing and potentially enabling access to structural elements, while more Nepali norms and values were preferred and retained in relation to certain maternal dietary habits and practices.

Contributions to the field of anthropology

By considering the so-far little studied topic of Nepali foodways in diaspora, this work contributes to existing anthropology in a number of ways. It identifies how a distinct group of the South Asian diaspora population – Nepalis living in Norway – engaged with food in relation to ideas about health and wellbeing, as well as with the biomedical healthcare structures of the state in the context of pregnancy and postnatal foodways. In so doing, it supplements the (growing) body of ethnographic research on South Asian groups in diaspora. It also makes a persuasive case for the value of longer-term ethnographic research in drawing out the localised particularities of people's eating habits and practices as they move into a new, in this case culturally very different, country – showing the changes that they undergo as well as any continuities that may persist from where they came. In the process this work has attempted to do what I think effective anthropological enquiries should, namely to highlight the importance of disaggregation in social analyses (my first key argument).

More specific to critical medical anthropology, meanwhile, was my respondents' creative, agentive and seemingly satisfying (to them) application of biomedical and other understandings of health in relation to general as well as ante- and postnatal foodways. This speaks to the ongoing debates surrounding the dominance and perceived acceptance within ideas of 'healthy eating' of a biomedically-predicated nutrition discourse, as well relating specifically to my second and third key arguments. It does so by highlighting the contingency of biomedicine, in terms of understanding (key argument number two) as well as of authority (key argument number four). Following on from this, as I have shown, the Nepalis I worked with at times combined a clear belief and appreciation of biomedical logics with ostensibly incompatible dietary habits and practices drawn from humoral and other principles. Their foodways in diaspora were, therefore, neither entirely or definitively 'traditional' nor 'modern'; nor were they of coherently different medical paradigms. This research thus also adds to existing accounts of diaspora food and health-related syncretism and pluralism practices (Bradby 1997; Dawes 2006; Harbottle 2004; Homans 1983; Wheeler & Tan 1983). Overall, my findings underscore the value of critical medical anthropology research in enabling movement beyond

biomedical models and framings to also take into account the wider political, social and cultural contexts in which matters of health and wellbeing are inextricably embedded.

Concluding comments

In taking seriously the non-biomedical aspects of Nepalis' dietary habits and practices and lifestyles in Norway, the major contribution of my ethnography is to add a different voice to the debate surrounding South Asian foodways in relation to health. Yet as the key arguments advanced above show, I also offer a broader analysis of the situation by identifying certain limitations within the Norwegian state's public health approach and discourse, using my ethnographic findings to make a clear and well-supported case for the need to look beyond their dominance.

With regard to future research, I think further exploration of health- and maternity-related foodways among diaspora populations – in Norway, as well as elsewhere – could yield interesting and important insights not only into immigrant habits and practices but also those of the host nations. My hope, in short, is that such enquiries might lead to dialogue, greater understanding and mutual appreciation of approaches between groups with different knowledge bases. And from this might arise opportunities for cooperation, rather than the piecemeal appropriation or instrumentalisation of knowledge by one group over the other that seems more common currently, at least in terms of public health attitudes to South Asian immigrants in Norway.

Appendix A – Information Sheet Given to Interviewees

English Version

INFORMATION SHEET

Thank you for meeting with me today.

My name is Thea Vidnes, and I am a student at Brunel University, UK, studying for a PhD in anthropology.

I am interested to learn from Nepali people living in Norway about the foods they eat, their ideas about food in relation to health, and especially in relation to diet and pregnancy.

Your participation is entirely voluntary. You are free to stop at any time and there will be no negative outcomes for you if you decide to do that.

The conversations we have are intended to be relaxed – I would like to hear about your opinions and experiences. There are no ‘right’ or ‘wrong’ answers.

I will record what you tell me by taking handwritten notes and/or using a voice recorder. Anything you tell me will remain confidential because I anonymise all my notes and transcriptions of interviews.

The information that I gather from this research will be used to write my PhD thesis and might also feature in other publications I may write in the future (for example, academic articles). Your name will not be mentioned in any of these unless you specifically tell me you want it to be.

My main funding for this research comes through a PhD scholarship from Brunel University, UK.

If you have any questions now, or at any point during this or any other meetings we may have, please feel free to ask them.

Thank you for your time and interest!

Norwegian Version

INFORMASJONSSIDE

Takk for at du ville møte meg i dag.

Jeg heter Thea Vidnes, og jeg er student ved Brunel University i England og studerer til en doktorgrad i antropologi.

Jeg er interessert i å lære av nepalesiske folk som bor i Norge om maten de spiser, deres ideer om mat i forhold til helse, og spesielt i forhold til kosthold og graviditet.

Din deltakelse er helt frivillig. Du står fritt til å stoppe når som helst, og det vil ikke ha noen konsekvenser for deg hvis du bestemmer deg for å gjøre det.

Samtalene vi har er ment å løse og avslappet - jeg vil gjerne høre om dine meninger og erfaringer. Det finnes ingen "riktige" eller "gale" svar.

Jeg vil notere meg det du forteller meg ved å ta håndskrevne notater og/eller ved hjelp av en diktafon. Det du forteller meg forblir helt konfidensiell og jeg kommer til å anonymisere alle mine notater og transkripsjoner av intervjuer som blir gjort.

Informasjonen som jeg samler gjennom denne forskningen vil bli brukt til å skrive min doktorgradsavhandling, men også i andre publikasjoner jeg kan komme til å skrive i fremtiden (for eksempel vitenskapelige artikler). Ditt navn vil ikke bli nevnt i noen av disse med mindre du spesifikt ønsker at navnet ditt skal være med.

Midlene til denne forskningen kommer hovedsakelig gjennom et doktorgradsstipend fra Brunel University.

Hvis du har noen spørsmål nå, eller på et annet tidspunkt i løpet av dette eller andre møter vi måtte ha, må du gjerne spørre eller ta kontakt med meg.

Takk for din tid og interesse!

Appendix B – Background Information Sheet

English Version

- Now that you have the information sheet, do you have any questions?
- If you are happy that you have understood the information, please could you confirm to me whether you would like to continue and take part in this study?

BACKGROUND INFORMATION

Age:

Sex:

Place of birth (country and town):

Nationality (including caste &/or ethnic group):

Marital status:

– if married, age at marriage:

– nationality & age of spouse:

Children:

Age

Sex

Place of birth (incl. if in hospital or other)

– age at birth of first child:

Number of years lived in Norway:

Reason for living in Norway:

Current place of residence in Norway (town, suburb):

Able to speak Norwegian? (If so, how well, e.g. any exams passed?):

Who lives in the household:

Education/Training (including place where obtained):

Current employment/work:

How long do you plan to stay in Norway? (Do you plan to live in Nepal in the future? Or somewhere else?)

Health matters (long-term conditions or any significant health problems):

Smoking history:

Alcohol history:

Vegetarian? (+/- fish?):

Norwegian Version

- *Nå som du har informasjonssiden, har du noen spørsmål?*
- *Hvis du har forstått informasjonen, kan du bekrefte for meg om du ønsker å fortsette videre og ta del i denne studien?*

BAKGRUNNSINFORMASJON

Alder:

Kjønn:

Fødested (land og sted):

Nasjonalitet (herunder kaste og/eller etnisk gruppe):

Sivil status:

- Hvis gift, alder ved ekteskap:

- Alder og nasjonalitet ektefelle:

Barn:

Alder Kjønn Fødested (inkl. hvis på sykehus eller lignende)

- Alder ved fødselen av første barn:

Antall år bodd i Norge:

Årsak til å flytte til Norge:

Nåværende bosted i Norge:

Hvem bor i husholdningen:

Utdanning/opplæring (inkl. læringssted):

Nåværende stilling/arbeid:

Hvor lenge har du tenkt å bo i Norge? (Har du tenkt å bo i Nepal i fremtiden? Eller et annet sted?)

Helsetilstand eller noen betydelige helseproblemer:

Røyking historie:

Alkohol historie:

Vegetarianer? (+/- fisk?):

Appendix C – Interview Schedule

English Version

Interview Guide For Initial* Meeting With A Participant

** This does necessarily mean the first meeting, but one early on in the research process.*

1. What sort of things do you do to keep connected with your Nepali ‘side’ now that you live in Norway? What are the key things for you that maintain your sense of being Nepali?

Food & Drink General – Part 1

2. Which Nepali foods do you eat regularly now you live in Norway?

– How often?

– How easy is it to find these foods (or their ingredients) here?

3. When you visit Nepal, which foods/drinks do you bring back to Norway with you? Or ask others to bring back for you?

4. In what ways have your food habits changed since you started living in Norway?

5. Are you satisfied with your diet here in Norway? Is there anything you would like to change about it?

Diet, Wellbeing & Illness

6. Which foods/drinks do you feel make/keep you well? What, for you, are healthy food/drinks?

– Any you avoid because you think they are unhealthy, they do not make you feel well?

7. Which foods/drinks are important to have when you are feeling unwell?

– Or that you feel are necessary to avoid if feeling unwell?

8. Are there some foods/drinks that you think are particularly important to have at certain times in life?

– When young (babies, children)?

– When old?

– Other times, e.g. when a woman menstruates?

9. Have you ever been on a diet? Are you concerned about your body shape/size?

Diet, Pregnancy & Advice

[If you are not a parent, continue with this question; if you are a parent, go straight to question 12.]

10. Which foods/drinks do you think are particularly important for a woman to have when she's pregnant?

– Or that she should avoid?

11. Which foods/drinks do you think are particularly important for a woman to have soon after she has given birth?

– Or that she should avoid?

[If you are a parent, continue with this question; if you are not a parent, go straight to question 19.]

12. When you were/your partner was pregnant, did you/they have any special food or drinks?

– Any that you/they avoided?

13. Were you/they given any advice about what you/they should eat or drink while you were/your partner was pregnant? (*What was it? Who gave it?*)

14. In the time soon after you/your partner had given birth, did you/they have any special food or drinks?

– Any that you/they avoided?

15. And any advice given about what to eat or drink then? (*What was it? Who gave it?*)

16. When you were/your partner was pregnant, was there anything else you/they did differently?

17. And any advice given about what you/they should or should not do?

(*What was it? Who gave it?*)

18. Were you given any leaflets or other information to keep?

(*What can you remember about them? Who gave them?*)

19. Since coming to Norway, have you been given any advice about what you should eat or drink to be healthy? (*What was it? Who gave it?*)

20. Were you given any leaflets to keep or seen other information about this?
(*What can you remember about them? Who gave them? Where?*)

Food & Diet – Part 2

21. How do you decide what food and drinks to buy?
(*Cost? Appearance? Taste preference? Other factors?*)

22. What do you like to eat or drink between meals, i.e. as snacks?

23. At what time do you normally eat your meals? (And who with?)

24. Can you describe what you would eat and drink in a typical day. For example, talk me through what you had yesterday.

25. Is there anything different/special that you eat at weekends, compared to during the week?

26. If you compare a Norwegian diet and a Nepali diet, would you say that one is healthier than the other? If so, which and why?

Thank you very much!

Norwegian Version

Intervju for Innledende* Møte med en Deltaker

* Dette betyr ikke nødvendigvis det første møtet, men ett tidlig i forskningsprosessen.

1. Hva gjør du for å ta vare på din Nepalesiske bakgrunn nå som du bor her i Norge ?

Mat og kosthold – Del 1

2. Hvilke Nepalesisk mat spiser du regelmessig nå som du bor i Norge?

- Hvor ofte?

- Hvor lett er det å finne disse matvarene (eller ingrediensene) her?

3. Når du besøker Nepal, hvilke mat/drikke (hvis noen) tar du med tilbake til Norge? Eller ber andre om å bringe tilbake for deg?

4. På hvilke måter har dine matvaner endret seg siden du kom til Norge?

5. Er du fornøyd med kostholdet ditt her i Norge? Er det noe du ønsker å endre på det?

Kosthold, Velvære og Sykdom

6. Kan du fortelle meg om det er noe spesiell mat/drikke som du mener gjør/holder deg frisk?

- Ellersom du unngår fordi du tror de gjør at du føler deg uvel/usunn?

7. Kan du fortelle meg om det er noe mat/drikke som du føler er spesielt viktig å få i deg når du selv er syk??

- Eller som du mener man bør unngå?

8. Kan du fortelle meg om det er noe mat/drikke som du synes er spesielt viktig å spise/drikke i bestemte faser i livet?

- Som ung (spedbarn, barn)?

- Som gammel?

- Andre ganger, f.eks når en kvinne menstruerer?

9. Har du noen gang vært å slanke seg? Er du bekymret over din kroppsfasong/størrelse?

[Hvis du ikke er en forelder, fortsett med dette spørsmålet;. hvis du er en forelder, gå direkte til spørsmål 12.]

10. Kan du fortelle meg om noe mat/drikke som du synes er spesielt viktig for en kvinne å ha når hun er gravid?

- Eller som hun bør unngå?

11. Kan du fortelle meg om noe mat/drikke som du synes er spesielt viktig for en kvinne å ha kort tid etter at hun har født?

- Eller som hun bør unngå?

[Hvis du er en forelder, går du videre til neste spørsmål; hvis du ikke er forelder, gå rett til spørsmål 19.]

12. Når du var/partneren din var gravid, var det noe spesiell mat/drikke du/hun spiste eller drakk?

- Eller som du/hun unngikk?

13. Når du var/partneren din var gravid, ble du/hun gitt noen spesielle råd om hva du/hun bør spise eller drikke? (Hva slags råd var det? Hvem ga rådene?)

14. I tiden like etter at du/din partner hadde født, fikk du/hun noe spesiell mat eller drikke?

- Eller som du/du unngikk?

15. Og ble du/hun gitt noen spesielle råd om hva du/hun bør spise eller drikke? (Hva slags råd var det? Hvem ga rådene?)

16. Når du var/partneren din var gravid, ble det noe annet du/hun gjorde annerledes?

17. Ble du/hun gitt noen spesielle råd om hva du/hun burde eller ikke burde gjøre?

(Hva slags råd var det? Hvem ga rådene?)

18. Fikk du/hun noen brosjyrer eller annen informasjon som dere kunne beholde?

(Hva kan du huske om dem? Hvem ga dem?)

19. Siden du kom til Norge, har du fått noen spesielle råd om hva du bør spise for å være sunn?
(Hva slags råd? Hvem ga disse rådene?)

20. Fikk du noen brosjyrer eller har du sett annen informasjon om dette?
(Hva kan du huske om dem? Hvem ga dem? Hvor?)

Mat og kosthold – Del 2

21. Hva er det som bestemmer hva slags mat og drikke du kjøper?
(Pris? Utseende? Smaks preferanse? Andre faktorer?)

22. Hva liker du å spise eller drikke mellom måltidene, dvs. som snacks?

23. På hvilken tider i løpet av dagen bruker du vanligvis å spise måltidene dine? (Og hvem spiser du vanligvis med?)

24. Kan du beskrive hva spiser og drikker i løpet av en vanligdag. For eksempel, fortell meg hva du spiste og drakk i løpet av dagen i går:

25. Er det noe annerledes / spesiell at du spiser på helgen, sammenlignet med i løpet av uken?

26. Hvis du sammenligner en Norsk kosthold og en Nepali kosthold, mener du at en er sunnere enn den andre? Hvis ja, hvor og hvorfor?

Tusen takk!

Appendix D – Kotürk-Runefors’s Model Of Immigrant Dietary Change In Relation To Migration

This model has gained considerable currency as an explanatory device within Norwegian biomedical public health research discussed in this thesis, and especially when accounting for the variable ‘culture’ (see, for example: Garnweidner 2013; Holmboe-Otteson & Wandel 2012; Kumar & Viken 2010; Malla 2005; Mellin-Olsen & Wandel 2005; Wandel et al. 2008). And although the substance of Kotürk-Runefors proposals are not central to my own arguments, given the site of my research (Norway) and that a principal concern of that is the inter-relationship between Nepalis living there and the state’s biomedically-predicated linking of health and diet, an explanation of her model is warranted.

In the early 1990s, Tahire Kocktürk-Runefors, a Turkish-born nutritionist by that time living and working in Sweden, proposed a model she had developed in a bid to better understand the “the structure of food combination patterns in different cultures and the process of adaptation to new dietary pattern” (Kocktürk-Runefors 1991: 185). Based on her research with immigrant groups in Sweden, citing Peryam (1963), she asserted that food groups exist in a two-part hierarchy when it comes to meal composition. The first, more significant group, which she termed ‘basic foods’, comprised a ‘staple’ (usually grains or tubers, for example rice, potatoes, yams) and potential ‘complement’ (fish/meat/eggs, milk/cheese, vegetables, legumes); the second group, ‘accessory foods’ (fats, sugars, herbs, spices, nuts, fruits and drinks), feature to add flavour and aesthetic appeal (“presentability”) to the basic foods (ibid: 186 – 87).

BASIC FOODS

Staple

rice, wheat, corn, millet

Complement

meat, fish, eggs

milk, cheese

vegetables

legumes

ACCESSORY FOODS

fats, spices, nuts,

sweets, fruits, drinks

Figure 5. ‘Basic foods; and ‘Accessory foods’ (Adapted from Koctürk-Runefors 1991: 186)

Relating food to cultural practices, Kocktürk-Runefors was categorical in her assertion of the significance of staple foods: “It is impossible to compose any type of a culture-specific dish if the appropriate staple is not available” (ibid: 186 – 88). Nonetheless, on their own they were insufficient to connote a meal, the complementary foods acting to do so. Accessory foods, meanwhile, were deemed “not as vital for the survival of a kitchen tradition” (ibid: 188). As a result she identified certain rules pertaining to the definition of basic and accessory foods, effectively opposites of each other.

For basic foods the rules were, firstly, that a basic food could, if necessary, “form a dish in itself” – it is possible to have, for example, only rice or only eggs and still call each a dish. Secondly, it was “impossible” that one particular staple could be substituted for another without definitively altering both the name of the dish and its association with a particular culinary tradition (ibid: 186 – 88). The example she gave, that substituting pasta for rice in Spaghetti Bolognese effectively rendered the dish more akin to the Malay or Indonesian specialty, Nasi Goreng, is not entirely convincing: Nasi Goreng: at its core, Nasi Goreng constitutes fried, not boiled (as the pasta would have been) rice; nor does it allow for the Italian style seasoning of the Bolognese sauce, which is likely very different from any equivalent meat sauces coming out of a more traditional Malay or Indonesian culinary repertoire. Nevertheless, the point made, albeit a likely over-simplification, is potentially useful to think with.

For accessory foods, the reverse thus applied: served on their own, they could not comprise a meal, and “at the most be considered as snacks”; moreover, accessory foods did, in Kocktürk-Runefors’s judgement, permit substitutions. Again, using the example of Spaghetti Bolognese, she contended that in substituting the usual fat (olive oil) and herb (basil) for margarine and thyme respectively, the dish could still be recognisable as Spaghetti Bolognese. And while conceding that the lack of certain accessory foods would lead to a particular culinary tradition “suffering”, it would not necessarily lead to its “disappearance” (ibid).

Building on this basic premise, the nutritionist thus developed a model to account for how migration-related adaptation to a new foodways pattern occurs (see Figure 2. below). Again not shy of making absolute statements – “Food is that component of culture which is easiest to carry along when one moves to another country” (ibid: 188) – Kocktürk-Runefors, like many anthropologists and sociologists mentioned in this thesis (see, for example: Caplan 1997; Carsten 1997; Fischler 1988; Murcott 1996; Mintz & Dubois 2002; Ray 2004), regarded food as a principal means for people to positively assert their identity. With migration, certain shifts are however inevitable and her model attempted to delineate these by identifying dietary change as

a temporal process with ‘taste’ and ‘identity’ at opposite poles, working as opposing forces in affecting change.

Staples she hence identified most strongly with identity and thus were cleaved to the longest, while accessory foods – considered less linked to cultural identity and more a consequence of personal taste – were deemed more likely to change early on (ibid: 188). Moreover, “cultural prejudice” towards accessory foods was apparently lesser due to them being regarded as not “real food”; rather, she likened them to “gastronomical toys”, used to decorate and enhance sensory pleasure, but “we do not take them very seriously” (ibid: 189).



Figure 6. Model relating ‘Identity’ and ‘Taste’ to changing food habits of immigrants (Adapted from Koctürk-Runefors 1991: 189)

Extending this reasoning to mealtimes, Kocktürk-Runefors argued that those meals considered to bear the greatest cultural weight were the last to alter in response to the new work- and leisure-time activity patterns that moving to a new country usually presented (as the Nepalis I worked with also experienced – see Chapter 4). Thus, according to her model, shifts began first with snacking, then breakfast, then lunch. Evening meals (as well as special occasions), in contrast, were identified as the mealtime when family and friends most commonly congregated, “reserved for strengthening the sense of belonging and identity”, and when “home country cooking” predominated (ibid: 191). Hence it was the slowest to evince change.

Kocktürk-Runefors maintained her uncompromising rhetorical style throughout what is a short chapter. Based on the existing studies and my own research experience, I would accept, with only mild reservations, her contention that adaptation of diet to a new culture “is complete only when immigrants begin routinely eating the staples of a host population – this may take a very long time” (ibid: 190). However, I am in considerably less agreement with her concluding two-

sentence paragraph: “Thus the answer to the question “do immigrants change their food habits?” is both yes and no. Yes, they change – at the accessory food level. And no, they do not change – at the basic food level.”

(ibid: 191)

According to my own findings (see Chapter 4) yet also others’, including Ray (2004), this assertion is simply too unequivocal.

Despite this, Kocktürk-Runefors’s model remains relevant to any discussion on potential shifts in immigrant foodways. It has considerable weight within public health and biomedical disciplines, at least as represented within Norwegian research and publications within these spheres. This is unsurprising given Kocktürk-Runefors’s professional background, work and location. Furthermore, although not central to the arguments of this thesis, her model is borne out at least to some degree by my own findings as well as those from other social sciences-based research with immigrant communities in the UK (Bradby 1997; Harbottle 2004; Homans 1983), and its application provides certain useful insights into the situation of immigrant foodways.

Appendix E – Figure 7: Table of Basic Demographic Information of Interviewees and Other Named Nepali Interlocutors

Pseudonym	Gender	Age (years)	Occupation	Length of Time Resided in Norway	Languages Spoken
Ambika	F	15 – 25	Undergraduate student	> 10 years	Nepali, English, Norwegian (fluent)
Anil	M	35 – 45	Works in hospitality services (previously postgraduate student in Norway)	> 5 years	Nepali, English, Norwegian (basic)
Annie	F	25 – 35	Works in health services	> 5 years	Nepali, English, Norwegian (fluent)
Arjun	M	25 – 35	Postgraduate student	< 5 years	Nepali, English, Norwegian (basic)
Ashok	M	45 – 55	Works in education	>20 years	English, Nepali, Norwegian (fluent)
Devi	M	35 – 45	Works in education (trained at a technical college in Norway)	> 10 years years	Nepali, English, Norwegian (fluent)
Ida*	F	–	Office worker	> 30 years	Norwegian, English
Indira	F	35 – 45	Works in health services (Undergraduate degree from Nepal)	> 10 years	Nepali, English, Norwegian (fluent)
Jyoti	F	25 – 35	Postgraduate student	> 5 years	Nepali, English, Norwegian (basic)
Kamal	M	35 – 45	Works in catering services	< 5 years	Nepali, English
Kusum	F	35 – 45	Undergraduate student (training to work in health services)	> 20 years	Nepali, English, Norwegian (fluent)
Lalita	F	–	Works in education (Undergraduate degree from Nepal)	> 5 years	Nepali, English, Norwegian (fluent)
Mangala	F	25 – 35	Full-time mother	< 5 years	Nepali
Maya	F	35 – 45	Works in health services (qualified as a doctor prior to coming to Norway)	> 5 years	Nepali, English, Norwegian (fluent)
Mira	F	25 – 35	Works in catering services	> 10 years	Nepali, English (intermediate), Norwegian (fluent)
Nayan	M	35 – 45	Works in health services (qualified and worked as doctor in Nepal prior)	> 5 years years	Nepali, English, Norwegian (fluent)
Nirmala	F	25 – 35	Works in education (Undergraduate and postgraduate degrees from Norway)	> 10 years	Nepali, English, Norwegian (fluent)
Padma	F	25 – 35	Full-time mother	< 5 years	Nepali
Parvati	F	–	Full-time mother (Professional qualification in Nepal prior)	> 10 years	Nepali, English, Norwegian (fluent)

Pseudonym	Gender	Age (years)	Occupation	Length of Time Resided in Norway	Languages Spoken
Pinkee	F	35 – 45	Teacher (Postgraduate degrees from Nepal and Norway)	> 10 years	Nepali, English, Norwegian (fluent)
Prithi	F	15 – 25	None currently (Undergraduate degree from Nepal)	> 5 years	Nepali, English
Puja	F	25 – 35	Postgraduate student	< 5 years	Nepali, English, Norwegian (basic)
Ram	M	25 – 35	Postgraduate student (qualified and worked as doctor in Nepal prior)	< 5 years	Nepali, English, Norwegian (intermediate)
Ravi	M	–	Works in health services (Postgraduate degrees from Norway)	> 10 years	Nepali, English, Norwegian (fluent)
Sanjay	M	35 – 45	Postgraduate student	< 5 years	Nepali, English, Norwegian (basic)
Sasmita	F	45 – 55	–	> 10 years	Nepali, Norwegian (fluent)
Shanti	F	35 – 45	Works in private sector (Undergraduate and postgraduate degrees from Nepal)	> 5 years	Nepali, English, Norwegian (fluent)
Sonam	F	45 – 55	–	> 10 years	Nepali, Norwegian (fluent)
Sonya	F	45 – 55	Works in private sector (Undergraduate degree from Norway)	> 20 years	Nepali, English, Norwegian (fluent)
Sunil	M	25 – 35	Postgraduate student	< 5 years	Nepali, English, Norwegian (basic)

F = female; M = male;

– = data not obtained

> = more than; < = less than

NB, Age ranges, rather than specific figures, are given to help preserve the anonymity of these respondents. For the same reason, areas of occupation feature and not specific roles/job titles.

* Ida was the Norwegian wife of Devi; she was the only non-Nepali family member encountered among the Nepalis that I worked with during fieldwork

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