

## Nutritional Habits among Women in Western Rajasthan: Gender, Culture, and the Ecology of Deprivation

Nikita Kumari Saharan<sup>1</sup> | Dr. Arun Kumar<sup>2\*</sup>

<sup>1</sup>Ph.D. Scholar, Singhania University, Jhunjhunu, Rajasthan, India.

<sup>2</sup>Assistant Professor, Singhania University, Jhunjhunu, Rajasthan, India.

\*Corresponding Author: nikitasaharan1998@gmail.com

*Citation: Saharan, N. & Kumar, A. (2026). Nutritional Habits among Women in Western Rajasthan: Gender, Culture, and the Ecology of Deprivation. International Journal of Education, Modern Management, Applied Science & Social Science, 08(02(I)), 145–150. [https://doi.org/10.62823/IJEMMASSS/8.2\(I\).9018](https://doi.org/10.62823/IJEMMASSS/8.2(I).9018)*

### ABSTRACT

*The nutritional well-being of women in western Rajasthan is in a precarious state – not merely due to the lack of sufficient food supply but more so because of the entrenched social structures that decide who, in the household, consumes what, how much, and when. This study examines the social structures through an intersectional approach by utilizing information obtained from the National Family Health Survey (NFHS-5, 2019-21) dataset, health reports from Barmer, Jaisalmer, Bikaner, and Jodhpur districts, and qualitative information acquired from various locations in rural and peri-urban areas. It calls out the existence of a phenomenon called the nutrition-gender-poverty trap, wherein anaemia, chronic energy deficiency, and poor nutrient status occur as a consequence of social inequality in accessing resources rather than merely as a result of shortage. Although programs like the POSHAN Abhiyaan Scheme and ICDS Scheme have been available, their execution is inadequate because of cultural appropriateness, geographic coverage, and implementation through suggesting policies that would help in overcoming the sociocultural barriers and not just focus on technological advancement.*

**Keywords:** Nutritional Practices, Gender Disparity, Anaemia, Food Stratification, POSHAN Abhiyaan, Malnutrition, Sociocultural Setting.

### Introduction

Asking a woman in a distant dhani in Barmer what she had for lunch can reveal quite a lot about how her family functions, rather than anything about what food they could obtain in their kitchen. In much of western Rajasthan, the issue of women's diets can never be separated from issues of power, responsibility, and affiliation. This is an arid landscape where natural conditions in the Thar Desert place some restrictions on growing and eating food, but where social restrictions on access to good food for women run even deeper than those of climate and geography.

Barmer, Jaisalmer, Bikaner, and Jodhpur make up close to 40 per cent of the area of the biggest state in India, but still, they are among the most malnourished areas of the entire country. According to the data of the National Family Health Survey of 2019-21, the prevalence of anaemia in women aged 15-49 years in Rajasthan is 54.4 per cent, while in rural low socioeconomic areas of Rajasthan, it rises to more than 60 per cent. In recent decades, nutritional outcomes in India have been improving significantly, but not in this part of Rajasthan (NFHS-5, 2021; MoHFW, 2021).

The academic studies on gender and nutrition in South Asia have clearly established the fact that women's eating practices and their nutritional status are not simply dependent on the food resources available within the household. Intra-household food allocation patterns, in terms of priority of access and

recognition of hunger, are governed not just by poverty but also by entrenched systems of gender beliefs (Harriss, 1990; Agarwal, 1994). The case of western Rajasthan is no different. Desert ecology, seclusion norms, early marriage customs, and caste-based systems of food segregation combine to create conditions of extreme nutritional deficiency in which women's health suffers disproportionately.

### Literature Review

**Amartya Sen** did pioneering work on 'missing women'; he pointed out that discrimination in the use of health care facilities and food adversely affects the survival chances of females, which later became clear through research done specifically on the topic of food distribution among family members (Sen, 1990; Pande, 2003).

**Bhatia & Cleland (1995)** discovered that there is a direct link between women's ability to make decisions at home and their nutrition levels in India. This correlation has consistently appeared in subsequent NFHS rounds.

Anaemia in Indian women during their reproductive years is one of the most enduring public health problems faced by the country. Iron deficiency is primarily responsible for anaemia. Other factors include the shortage of folate and B12 in addition to repeated infections, which add up to the strain on the body caused by frequent pregnancies (**ICMR, 2010; WHO, 2020**). In the state of Rajasthan, the prevalence of anaemia was reported due to diets deficient in iron intake and excessive intake of cereals rich in phytates.

**Coffey (2015)** persuasively contends, India's unusually high rate of anemia among its female population has nothing to do with diet and everything to do with the fact that these women have low social standing, which influences both how much nutrition they are able to consume as well as how much rest they receive, all while their bodies are simultaneously drained through pregnancy after pregnancy.

The nutrition transition theory put forward by Barry Popkin, explaining the development of diet from fibre-heavy and lean meat-based to calorie-dense processed food as nations become industrialised, has gained much attention, although it has been heavily criticized for the notion that such developments happen inevitably along an urban path (**Popkin, 1993; Shetty, 2002**).

The intersection between caste and nutrition in the state of Rajasthan is not well-explored within existing research literature, although it is very important in practice. The fact is that, although high-status castes like Rajputs and Brahmans follow a strict vegetarian diet, there might be a lack of iron, zinc, and vitamin B12 in the absence of nutrition interventions. Meanwhile, even though low castes like SCs and STs can enjoy a rich diet of meat and other animal products, their way of living makes them subject to nutritional deficiencies through a different set of mechanisms, namely hard work, irregular income levels, and lack of access to medical care (**Garg & Bhupender, 2014**). It is clear that there is no simple causation involved in this case study.

### Historical and Sociocultural Context

- **Desert Ecology and Dietary Constraints**

The change from the nomadic way of life of pastoralists in Barmer and Jaisalmer to a more permanent and market-based system has resulted in poor nutritional health among residents of these regions, especially women. As opposed to the earlier period when nomadism was practised, which facilitated access to nutrient-rich food such as camel milk, wild herbs, and leguminous products that were bought in the market, present-day settlements depend largely on commercial foods as well as drought-resistant crops such as bajra and moth beans.

- **Patriarchal Food Hierarchies and Female Self-Denial**

Patriarchal values have been prevalent for generations in western Rajasthan, significantly influencing the dietary habits of women in the region. The women often end up eating last and consuming leftovers, which is a norm that society considers righteous (\*seva\*). The tendency of society towards self-denial is frustrating when it comes to health interventions, as women voluntarily sacrifice themselves to meet the nutritional demands of men. In addition to this, the custom of \*purdah\* denies women access to important health services.

**Observations: Ground-Level Realities**

- **Rural Communities — Barmer and Jaisalmer**

The dietary pattern of women in rural locations in Barmer and Jaisalmer indicates serious malnutrition and structural weaknesses that involve the consumption of mere basics, such as bajra rotis and dal, with very few chances of consuming vegetables or iron-rich food sources. The poor nutrition practices in this regard have been shaped mainly due to patriarchal norms that compel women to eat whatever remains after others have consumed food.

*"Hum toh jo ghar mein banta hai woh kha lete hain. Sabse pehle bachon ko dena padta hai, phir pati ko. Jo bachta hai woh hamara hissa hai."* (We eat whatever is cooked at home. Children come first, then the husband. Whatever remains is our share.)- a 32-year-old mother

Even where camel milk in pastoral areas offers some proteins, the calorie consumption for women becomes much less than the enormous energy needed to perform domestic activities like fetching water and taking care of animals. As a result, anaemia and extreme fatigue among women have become common and socially acceptable facts of life, as reflected in the following quote from a 28-year-old woman in Jaisalmer:

*"Thakaan toh rehti hai, lekin kya karein — badan aisa hai. Dawai khaate hain kabhi kabhi, par farq nahi padta."* (Fatigue is constant, but what to do — the body is like this. We take medicine sometimes, but it doesn't seem to make a difference.) — Woman, 28, Jaisalmer district.

- **Peri-Urban Communities — Bikaner and Jodhpur**

In Bikaner and Jodhpur peri-urban areas, despite better availability of food sources, poor families have started consuming cheaper, very processed, and nutritionally poor food in the form of biscuits, maida-based products, and sweetened tea. Even though there is greater awareness about nutritional requirements among young females, especially concerning anaemia, it still proves challenging to act upon it. The primary reason behind this lies in the influence of family politics, high prices of healthy food items, and the sheer difficulty of catering to diverse dietary preferences within a joint family setting.

*"Mujhe pata hai ki iron ki kami hai, doctor ne bola bhi. Par ghar mein jo banta hai wohi khaana padta hai. Alag se kuch banana mushkil hai."* (I know I have an iron deficiency, the doctor told me too. But I have to eat whatever is cooked at home. Cooking something separately is difficult.) — Woman, 24, peri-urban Jodhpur.

**Analysis: The Nutrition-Gender-Poverty Nexus**

- **A Conceptual Framework**

The patterns of evidence identified above do not occur by chance. Instead, they occur because of three interconnected systems that this paper integrates into the Nutrition-Gender-Poverty Nexus. The first is the economic system – vulnerability, irregularity, and lack of food security that limit the total availability of food. The second is the gender system – the patriarchal nature of the family structure, food culture, and the meaning of food consumption among women. Finally, there is the institutional system – the ability of the state to provide nutrition programs that take into account the lives of women.

None of these systems exists in isolation from others. The lack of money leads to increased competition over food resources in the household, where gendered norms define the end result of the struggle. Programs of the state, despite the best designs, go through economic and gender lenses before they become useful for women. This is more of a framework than a schema.

- **Food Hierarchy as Structural Violence**

The structural violence concept by Paul Farmer (Farmer, 2004) explains the kind of violence that results from culture and a lack of institutions' concern, instead of deliberate acts of individuals. This is exhibited when practices in the community normalise cases of hunger and anaemia among women, which leads to poor physical indicators such as low levels of haemoglobin and birth weight of infants, without necessarily blaming anyone individually. This creates conditions where nutritional interventions do not work since there are inherent dynamics within the families that hinder them from success; for example, distributing supplementary foods to other family members or selling them in Rajasthan.

- **Depletion Cycle: The Reproductive Load and Nutritional Losses**

In western Rajasthan, the vicious cycle of malnutrition is caused by high rates of child marriage and fertility rates of 2.9 (NFHS-5). These women are commonly anaemic before reaching reproductive

age and go through constant cycles of early pregnancies, which continually drain their bodies of iron. To add to this problem, culture dictates their diets before and even after giving birth, making it impossible to regain their lost nutrition (Audichya & Singh, 2016).

- **Climate Variability and the Feminisation of Food Insecurity**

However, the ecological vulnerability of the Thar desert ecosystem is not static in nature but becomes increasingly threatened by climatic variations. The occurrence of droughts, which become more common in the regions of Barmer and Jaisalmer, leads to households experiencing food insecurity. However, under such conditions, gender relations pertaining to food sharing among household members do not become egalitarian; rather, they become more pronounced. In such situations, women begin to eat less food themselves. Simultaneously, women tend to take up heavier physical activity related to fetching water and agricultural activities in deteriorating farming conditions.

### **Key Issues and Challenges**

- **The Silent Burden of Anaemia**

Anaemia is an endemic problem among women in western Rajasthan, with 54.4% prevalence across the state and over 65% in disadvantaged segments (SC, ST, BPL). Despite the implementation of iron and folic acid supplementation for the past decade, compliance with the recommended dose of 180 tablets per pregnancy is less than 25%. The cause of this can be attributed to the side effects caused by medicines, lack of proper counselling, and rigid sociocultural practices that make women believe their fatigue and difficulty in breathing are simply due to excessive work, lack of sleep or fate.

- **Food Hierarchies within Households**

Allocation of resources within families is strongly embedded within society and is perpetuated by the internalisation of concepts such as devotion and sacrifice by women, not rules. Existing nutritional initiatives in clinics and anganwadis only provide remedies for the symptoms of inequality and do not address its underlying social causes. Although difficult, it is important that dialogue be facilitated among communities in order to resolve this social phenomenon.

- **Early Marriage and Compounded Vulnerability**

In Rajasthan, 40% of children suffer from the problem of child marriage, which creates a major nutritional emergency coupled with severe rights infringement. This results in curtailed educational opportunities for the girl children, preventing them from gaining nutritional awareness and self-reliance to make nutritious decisions and puts their developing bodies into early reproductive activities.

- **Institutional Gaps and Cultural Distance**

While there are already established policies such as ICDS, POSHAN Abhiyaan, and National Health Mission, the implementation of nutritional interventions in western Rajasthan still faces various systemic and cultural challenges. For one, infrastructure is inefficient because of the perpetual lack of skilled manpower, food supply, and vitamins. Moreover, the desert topography makes the process more costly. In addition, nutrition programs are often less effective since they are not customised based on the local culture. This includes issues related to caste, language, and wearing the veil.

### **Policy Recommendations**

The suggestions made below stem from the analysis provided above. These suggestions do not entail any technical improvements in current programs, but rather are meant as a shift in approach that acknowledges the social dynamics underlying women's effective access to nutrition policies.

- The POSHAN Abhiyaan needs modification to suit the desert regions and dispersed settlements.
- Iron and folic acid supplements should be combined with behaviour change communication in local languages. Marwari, Mewari, and Sindhi language speakers need health information in their local languages, disseminated through credible sources such as the dais, school teachers, and religious personalities, etc.
- Diversification of diet needs cooperation between agricultural, horticultural, and food security departments. By encouraging the cultivation of drought-resistant vegetables high in nutrients such as drumstick, amaranth, cluster beans, and moringa, women gain greater control over their diets, something that markets alone will not accomplish.

- Women should be given nutritional education.
- The ICDS infrastructure in poor western districts requires long-term investment, where the district must invest not in one-off capital outlay but continuous investment in health professionals who are local, culturally aware, and skilled in the languages of the local population.

To sum up, measures taken to prevent child marriages should be seen as an aspect of nutrition policy and not something else. Measures such as Mukhyamantri Rajshri Yojana, where cash incentives have been given to those parents who do not marry off their daughters and keep them in school, need commitment from policymakers and careful evaluation, not just for the purpose of gender equality but also for good nutrition.

### Conclusion

However, the nutritional status of women in Western Rajasthan is not simply a geographical quirk. Rather, it is a social problem rooted in the long-term marginalization of women within the Indian caste system, which makes their needs secondary, both within families, communities, and in the policy agenda itself. This may not make the situation any easier to resolve, but it can help to identify and understand the nature of the problem – a problem which involves more than lack of nutrition and malnutrition, but also power relations and cultural organization.

In the districts of Barmer, Jaisalmer, Bikaner, and Jodhpur, women bear a burden of undernutrition in silence, which is reflected in their constant state of exhaustion and chronic anaemia, as well as self-denial practised in the name of virtuous behaviour. Solving this problem will entail at least recognizing what the causes are behind it, as more than just drought and poverty. There is a domestic politics of food here, which eats away at the health of women in order to achieve familial harmony.

India's aspirations under POASHN 2.0, as well as its dedication to the SDGs relating to hunger and gender equality, will face their toughest test in areas such as western Rajasthan. Whether these aspirations make any difference to the lives of women living here will depend not just on how much money is budgeted or what coverage figures are produced, but on whether policy is ready to address social reality head-on.

### References

1. Audichya, S., & Singh, N. (2016). Postpartum dietary restrictions and nutritional status of women in rural Rajasthan. *Indian Journal of Community Medicine*, 41(3), 214–219.
2. Bhatia, J. C., & Cleland, J. (1995). Determinants of maternal care in a region of South India. *Health Transition Review*, 5(2), 127–142.
3. Coffey, D. (2015). Prepregnancy body mass and weight gain during pregnancy in India and sub-Saharan Africa. *Proceedings of the National Academy of Sciences*, 112(11), 3302–3307.
4. Deaton, A., & Dreze, J. (2009). Food and nutrition in India: Facts and interpretations. *Economic and Political Weekly*, 44(7), 42–65.
5. Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, 45(3), 305–325.
6. Garg, C., & Bhupender, S. (2014). Caste, class and nutritional status of women in India: A disaggregated analysis. *Journal of Health and Social Behaviour*, 55(2), 176–195.
7. Gupta, P. C. (2007). Nutritional ecology of the Thar Desert: Food systems and dietary adequacy. *Desert Ecology Monographs*, 3, 88–112. Jodhpur: Desert Research Institute.
8. Harriss, B. (1990). The intrafamily distribution of hunger in South Asia. In J. Dreze & A. Sen (Eds.), *The Political Economy of Hunger* (Vol. 1, pp. 351–424). Clarendon Press.
9. Indian Council of Medical Research (ICMR). (2010). *Nutrient Requirements and Recommended Dietary Allowances for Indians*. ICMR.
10. Kapil, U., Pathak, P., Tandon, M., Singh, C., Pradhan, R., & Dwivedi, S. N. (2002). Micronutrient deficiency disorders amongst children in Rajasthan. *Indian Paediatrics*, 36(2), 153–159.
11. Ministry of Health and Family Welfare (MoHFW). (2021). *National Family Health Survey-5 (2019-21): Rajasthan State Fact Sheet*. Government of India.
12. Pande, R. P. (2003). Selective gender differences in childhood nutrition and immunization in rural India: The role of siblings. *Demography*, 40(3), 395–418.

13. Popkin, B. M. (1993). Nutritional patterns and transitions. *Population and Development Review*, 19(1), 138–157.
14. Quisumbing, A. R., & Maluccio, J. A. (2000). Intra-household Allocation and Gender Relations: New Empirical Evidence from Four Developing Countries. FCND Discussion Paper No. 84. IFPRI.
15. Ramachandran, P. (2006). Nutrition transition in India: 1947-2007. *Public Health Nutrition*, 10(5), 371–378.
16. Rao, S. (2001). Nutritional status of the Indian population. *Journal of Biosciences*, 26(4), 481–489.
17. Structural Violence in Texas Counties: An Ethical Problem with Uncontroversial Policy Solutions | Journal of the Texas Tech University Ethics Centre.  
<https://ttuec-ojs-ttu.tdl.org/ttuec/article/view/47>
18. Shetty, P. S. (2002). Nutrition transition in India. *Public Health Nutrition*, 5(1A), 175–182.
19. Shroff, F., Shroff, F., Tsang, R., Schwartz, N., Alkhadragey, R., & Vora, K. (2022). Moreover, Still She Rises: Policies for Improving Women's Health for a More Equitable Post-Pandemic World—*International Journal of Environmental Research and Public Health*, 19(16), 10104.
20. World Bank. (2013). What Explains ICDS Performance in States: Case Studies from Andhra Pradesh, Madhya Pradesh, and Rajasthan. World Bank Report No. 74255-IN.
21. World Health Organisation (WHO). (2020). Worldwide Prevalence of Anaemia 2020 Report. WHO Press.
22. Tchounwou, P., & Zhou, J. (2014). International Journal of Environmental Research and Public Health Best Paper Award 2014. *International Journal of Environmental Research and Public Health*, 11(1), 1192–4.

