American Journal of Educational Research, 2015, Vol. 3, No. 7, 849-867
Available online at http://pubs.sciepub.com/education/3/7/8

DOI:10.12691/education-3-7-8

The Impact of Culture on the Nutritional Status of Children and Mothers Durrinng *Recurring Food Insecurity: The Case of Boreicha Woreda (SNNPRS)*

Abebe Demewoz Mengesha*, Tadesse Tesssema Ayele

Anthropology, Dilla University, Dilla, Ethiopia
*Corresponding author: abebedemewoz@yahoo.com, abebedemewoz@gmail.com

Received January 22, 2015; Revised April 01, 2015; Accepted June 12, 2015

Abstract The major goal of this study was to assess the impact of culture on the nutritional status of children and mothers during the recurring food in security with a particular reference to Boriecha Woreda, Sidama Zone in the Sothern Nations, Nationalities and Peoples Regional State (SNNPRS). The research was conducted into two purposively selected peasant associations (Kebeles) of Boriecha Woreda, Yirba- Duuwancho and Belila-Medolomukeanqa. This selection was based on the two reasons. The first reason is that both kebeles have health centers where malnourished children and their respective mother's receive health services. The second reason both kebeles are centers for the most drought prone areas compared to the other kebeles in the woreda. To achieve this goal, an attempt was made to collect the data in the study area by using different mechanisms. Qualitative research methodology was employed in the study for its appropriateness to explore the impact of culture on the nutritional status of children and mothers during the recurring food in security in the study area. However, with a limited degree the research was also utilized quantitative research method. Data was collected through the use of interview, focus group discussion, personal observation and document review. In the research areas, the targeted groups were pregnant and lactating women those who were suffering from malnutrition (under nutrition), mothers who had malnourished child, household head husbands of the family with the problem, the community elders, health post workers, religious leaders, aid delivery program workers were among others. The results obtained from the study suggest that the culturally patterned role and status of women and socially constructed gender hierarchy, in the study society, as well as the extended and unplanned family structures found directly contributed for the recurrence, frequency and prevalence of acute, moderate and severe malnutrition (under nutrition) among children (<5), lactating and pregnant mothers.

Keywords: *culture, children, recurring food insecurity*

Cite This Article: Abebe Demewoz Mengesha, and Tadesse Tesssema Ayele, "The Impact of Culture on the Nutritional Status of Children and Mothers Durrinng *Recurring Food Insecurity: The Case of Boreicha Woreda (SNNPRS)*." *American Journal of Educational Research*, vol. 3, no. 7 (2015): 849-867. doi: 10.12691/education-3-7-8.

1. Introduction

1.1. Background of the Study

The second most populous country in Africa, Ethiopia's estimated 77million population is growing at 2.9 percent a year, equivalent to 40,000 births per week. About 80% of the population lives in rural areas, where an estimated 50 % of the land is degraded. The dominant agricultural sector fuels growth but it is highly dependent on rainfall. About 30 million people (47.5 percent of the population) live below poverty line [31].

Despite economic growth and the government's commitment to combating poverty in general and food insecurity in particular, Ethiopia is still highly vulnerable to seasonal food crises. "Only 10 percent of cereal croplands are irrigated. Rainfall, most of agricultural production depended, has become more erratic since 1990's with more frequent occurrences of the El Nino phenomena. About 12 percent of the population is affected by recurring local draught each year."(Ibid) Besides this natural and seasonal challenge of the country, there are other possible factors that aggravating food insecurity in Ethiopia like population density, infrastructure development, land degradation, the rise in food and service prices and poor harvest management are among the others. From all these facts it is possible to deduce that food insecurity is the major factor for the occurrence of malnutrition with in a household, this is because in its conventional definition 'food security, at household level, exists when all members, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life…' [24] Therefore the opposite of this is food insecurity that considered being one of the main causes of malnutrition which occurs from Ethiopia is the country with population that is one of the most

nutritionally deprived in the world. That, according to the 2007 demographic health surveys 'the prevalence of wasting is 10.5 percent, which is above the threshold defining a nutritional alert. The country has also the highest rate in Africa for stunting-45 percent- and underweight- 38 percent' [4].

Malnutrition is more prevalent among the rural than urban parts of Ethiopia that mainly manifested among children (under 5), lactating and pregnant women where the country' child mortality rates 123/1000 (Ibid).These group members of a household are more vulnerable t o malnutrition because they need additional and adequate nutrient- rich foods as well as health and sanitation care than the rest of others even in the state of food security. When recurrent food insecurity occurs within a community or a house hold in Ethiopia children (under 5) lactating and pregnant mothers are the most vulnerable groups. Even with conventional relief aid supply, that distributes full food and calorie package for the communities facing food shortage, the challenge of children and mothers malnutrition remains persistent for long intervals. As the result of which' the clinical treatment –Enhanced Outreach strategy (EOS) –is designed by MOH and UN aid agencies with the program focusing on children under 5 and pregnant and lactating women to provide accesses to health care(vitamin A supplementation , Vaccination and medication) etc. [8].

Therefore, the inability of the conventional relief aid programs to alleviate the malnutrition of those members of households, during the recurring food insecurity within a community, demands for further investigation to find out the impacts of the cultural settings of a given society upon the nutritional status of children and mothers. As the result, this research is an attempted to investigate those cultural factors equally affecting and determining the nutritional status of children and mothers besides those universally accepted physical, biological, environmental and demographic factors. The research was conducted in Boriecha Woreda (Sidama Administrative Zone) in the South Nations, Nationalities and Peoples Regional state (SNNPRS). This was simply because one of the two researchers has had deep rooted experience of this woreda and the problem under study when he was working as the team leader for the relief and emergency aid monitoring joint task force as an employee of one of the leading aid organizations during the 2008 humanitarian crisis in the different regions of the country

1.2. Statement of the Problem

In Ethiopia, approximately 8 million rural people are estimated to be chronically food – insecure; a further 7 million at risk of periodic acute food insecurity from the draught, flood, animal disease, HIV/AIDS and social conflict. (MOFED, 2006) Chronically food – insecure households in rural areas are that may not meet their food needs during the time of disaster and emergency that appears repeatedly after intervals. Even the recent years figures of relief statistics indicated that in 2006,2007, 2008; the estimated numbers people with the need to food assistance were 2,579,651; 1,36 million; 2,181467 respectively (Government& partners appeals: 2007, 2008). Out of all these figures of beneficiaries each year the 35 percent of the total beneficiaries are expected to be children under 5, lactating and pregnant women [31] this is a group of beneficiaries with special assistance and care simply because they are vulnerable to malnutrition and that is why they need to be provided additional supplementary food.

Even these groups of beneficiaries are supported with special considerations and care, one of the two researchers personally observed in the targeted woreda in the SNNP regional state, large proportion of children and lactating and pregnant women were admitted in Health Center of this woreda for the therapeutic feeding with the aim of 'reducing mortality by providing clinical treatment for severely malnourished individuals'. (Ibid: 111) Within the Zone where the research was conducted, the researchers observed one health center in the Borecha woreda with total of 84 children with the same number of mothers. This figure shows only the situation during the 2008 humanitarian crisis in the country. (Field Report to DPPA &WFP [7,8]).

However, multi-dimensional efforts have been made to alleviate the problems of food insecurity in general and malnutrition in particular in the country and to maintain its sustainability at the household level. These efforts can be categorized in to two directions. The first goes to the efforts made by the national and international relief, aid and development agencies. 'Ethiopia is one of the first three countries getting food, technical and developmental aid in the world.' [8] The second category of efforts belongs to the efforts of number of scholars both from outside and inside the country to discover the root causes of the problem. These academicians have made variety of distinguished researches to find out the root causes food insecurity in particular and poverty in general in the rural households of the country. And they find out variety of factors for the problems such as drought and famine, Triggering, Predisposing, and Aggravating factors , Livelihood Strategy [29] are among others. Also variety of theoretical orientations are associated with the problems of food insecurity in households with different factors including structural constraints, accesses for resources, governance, underdevelopment, dependency, and other many more factors.

Hence the fundamental question that logically could be deduced from the above discussion as matter of inquiry for our research was that 'After all these efforts of humanitarian provision of basic human needs, 'what factor(S) remains behind the persistence malnutrition of children and mothers with in the households?' Why only children and their mothers are the most vulnerable? The researchers assumed that this underlying factor might be the cultural thought and behavior of the society that could possibly influence the nutritional status of the targeted groups within the household in the Boreicha Woreda of SNNPRS. Because the attribute of human food is culturally patterned beyond its universal biological importance.

1.3. Objectives of the Study

1.3.1. The Main Objective of the Study

The main objective of the study is to investigate the extent and level of the influence of cultural patterns upon the nutritional status of children (under 5) and lactating and pregnant women at household level and to find out the

root cultural factors for their vulnerability to persistent malnutrition in the time of recurring food crisis in Boreicha woreda (SNNPRS)

1.3.2. Specific Objectives of the Study

The research was conducted in order to address the following specific objectives:

- Examining the norms and values of the community towards children and mothers nutritional status and its maintenance.
- Assessing cultural patterns of the community on gender allocation of power and prestige on the household economic resources.
- Identifying the root causes of children and mothers malnourishment in the recurring food crisis from within the household.
- Investigating both the positive impact and the possible failure of the efforts of the relief programs in improving the nutritional deficit of children and mothers under study

1.4. Research Questions

The research basically addressed the following basic questions

- What are the root causes of the recurring food insecurity appeared within intervals of years?
- What cultural patterns are determinant on the nutritional status of children and mothers?
- Who is responsible for the resource control in the household economy where the family is headed by male?
- What culturally patterned conception exists towards children and mothers in terms of their nutritional status?
- Whether malnourishment is only related to poverty and lack of access or there are other social and cultural factors effecting the problem?

1.5. Significance of the Study

This research work has an intention to bring about dual contributions of knowledge (academic) and practice (applied) towards the nutritional status of children and mothers in the cultural context of rural Ethiopia.

First of all, concerning the cognitive significance of the study, most of the scholars dealt with the problem of food insecurity and malnourishment in Ethiopia hitherto were mainly linked the issue with factors such as environment, demography, economic, infrastructure, poverty and policy among others. And also some were measuring the problem only from an angle of food availability or scarcity at household level. [20,24,29]. however, this study was attempted to link the problem of malnutrition with the particular cultural context where ever it appeared and to the specific group of the members of the household: children and mothers. In this respect the findings of the study are anticipated to add a little toward enriching the hitherto literature gap on comprehending the causes of the subject under study.

On the other hand, concerning its practical significances, the findings of the study may be useful for policy makers, government and none-government relief agents, UN organs and others who are working in relief programs in the country to evaluate and redirect their interventions towards improving the nutritional status of the children and mothers in the rural Ethiopia.

1.6. Lmitations and Delimitations of the Study

1.6.1. Limitations of the Study

Because resource constraints and other potential difficulties the researchers are identified the following possible limitations:

Even the research has envisioned arriving at a very broad generalization about the nutritional status of children and mothers in the households of the rural Ethiopia, the sample size, from which its premises are actually collected, was only from limited woreda of SNNPRS. However, by the virtue of being social (cultural) anthropologists, the researchers have tried to apply the skill and perspectives of the discipline to bridge the gap.

Since the research attempted to collect reliable data from the inner part of the cultural thought and behavior of the group under the study, most of female informants were reluctant to tell all the truths that they conceived, it is taboo to be told to non natives and conspiracy against their masters. To avoid such difficulties it needs further observations and triangulation which in turn needs more resources.

It is also equally important to expect challenges such as transportation, service accommodation, compiled secondary data from respective local offices because most of the research areas are very far and remote rural localities. However, the researchers have tried to work hard to minimize the effects of all these and other limitations on the objectivity of it findings.

1.6.2. Delimitation of the Study

This research was an attempted to investigate the impacts of the cultural reality of the society upon the nutritional status of children under five years, pregnant and lactating women in the Boreicha woreda (Sidama Administrative Zone).The research was delimited to these groups of the members of households and site of the study because of two possible reasons. On the one hand, Children bellow 5 years and pregnant and lactating women are the groups of a family most vulnerable to malnutrition (even to acute malnutrition) during the situation of recycling food insecurity when it is compared with the rest of the members. On the other hand, this study woreda was also the most susceptible area to recurring food insecurity and with long lived records of children and mothers malnutrition from 2001-2008 [8].

2. Background of the Study Area and the Research Processes

2.1. Background of the Study Area

The study was conducted in Boricha Woreda of the Sidama Zone in the Southern Nations, Nationalities and People Regional State (SNNPRS). The Sidama is named for the Sidama people whose homeland located in this zone that consists of 19 Woredas of which Boricha is the

one. Before discussing the study woreda is proper to deal with that the Sidama zone in which the former is a part.

2.1.1. The Land

Sidama zone is one the most fertile and the most densely populated areas in Ethiopia that make up about four percent of the total Ethiopian population. The staple food of the Sidama, enset (false banana) is the very drought resistant (though it has periodically suffer from a virus diseases which has caused serious and frequent food shortages), and allows under normal condition a dense population in relatively small area. The Sidama land also provides valuable resources to the economy. The most important contribution is cash crops, mainly coffee but also khat (an ever green shrub whose leaves are chewed as stimulant) and other agricultural yields.

Location of the sidama Zone is in south central parts of Ethiopia, to the east and north east of the Lake Abaya and to the east and south east of the Lake Hawassa. The midlands contain a continuing of chain of villages, while in the highlands are a little more scattered. On the open savanna in the lowlands (including the study woreda) settlements are even more scattered [2]. Parts of the Sidama land are located in the famous the East African Rift valley, the deep volcanic rift which starts in the Middle East and pass through eastern Africa down to Mozambique before stretching the Indian Ocean. The lowland to the west of sidama, including half of the Lake Abaya and Lake Hawassa, are on the floor of the rift valley. (Ibid)

2.1.2. Occupations

The main occupation of the rural Sidama people is farming, and 1,783 square kilometer is cultivated land where 85 percent of the total population (i.e. 2,954,136 with nearly equal proportion of men and women), are farmers. [4] Coffee is the most lucrative cash crop. Khat market has become another huge cash crop market in the last few years. But basically the Sidama people cultivate a variety of grains and fruits for the households and local consumption. They also depend on the dairy products [2].

2.1.3. Socio-Cultural Contexts of the Sidama People

For any social science which attempts to investigate the cultural issues and their influence, like ours, this section may contribute a lot to have subsequent information about the people under investigation.

The language

The sidama people speak their own Cushitic sidama (locally as sidamoo afe) language that belongs to the eastern highland Cushitic sub-group of the Ethio-Cushitic family of languages. The language shares some basic phones, morphemes and syntaxes with other languages within the same sub-groups such as Gedeo, kambata, Hadiya and the like which also known as the sidama languages in eastern highland Cushitic sub groups [21].

The Social Structure

The traditional Sidama community said to have emerged in the sixteenth century about 20 generations ago. Until the emperor Minilik II incorporated the sidama in to the Ethiopian empire, the Sidama existed as tribal unite with several kingdoms. The Sidama is defined as an ethnic group which is the most inclusive level of social organization and that inhabit a distinct area as a homogeneous ethnic group.

There are three traditional and cultural administrative structures in the Sidama society which reflect and govern the basic principles of the social structure and relation. These traditional structures are based on patrilineal purity and seniority. Based on this a series of patrilineal sub tribes and subdivisions of sub tribes are stratified in to different hierarchical levels, clans and families. While the highest ranking groups have a legitimate right to posses land but the lower has no right mostly considered as impure and occupy the artisanship [2].

The Sidama has highly stratified patrilineal social structure and patriarchal family structure. Sub tribes (gosa) are divided in to three levels. First, the bisallo i.e. clans, second, the aydde: division that consist all descendants of one ancestor for about the three or five generations and which consists an olla (village). Third, mine; (house) the nuclear monogamous or polygamous family. Based on this social structure, there are nine sub tribes in the Sidama society: Alatta, Haweela, Qeweena, Saawoola, Fagisa, Garbicho, yanase, Malga and Holloo. This series of the sub tribes are in descending order of hierarchy (ibid). From this analysis it is interesting to see that the Sidama society is highly stratified society in its social structure.

The cultural daily life in the Sidama society has traditionally been organized around the social network within the Ola (village) or within the mine, the family unit which are governed by powerful male elders. In all traditional authorities, only the elder and only the man have an absolute right to make decision. This social rule and truth, referred to as halale, proclaimed by masculine elders is hard to challenge and is a base for forced consensus. (Ibid) Therefore, in the society, children and their mothers are voiceless participant who are simply occupying the lower stratum in decision making because their age and sex status.

Based on this background study of the Sidama zone administration, we need to proceed to the study woreda which is one of the nineteen woredas of the zone and that shares all attributes of the sidama society mentioned just above.

2.1.4. The Study Woreda

The Boricha Woreda located to south-west of Hawassa, the capital of the region. Approximately between 6.84 X and 7.02 X North and 38.52 X and 73X East with the area of 39504 KM X. It shares boundaries with Wolayta in the Western Zone, Gamogofa Zone in the South East, and to other sidama woredas in the rest of the directions.

According to the 2007 population and houses census of Ethiopia, the Woreda has the total population of 288, 713, of which 144,811(50.1%) are male while 143,902(49.9%) are female. The great majority of the population goes to the people in the rural areas. That is 280,821(97.26%) are Urban dwellers and highly dependent on agricultural production. The Woreda population size expected to be increased with 8,373 people per each calendar year. This figure makes the woreda the first with both population size it is increasing [4].

The Woreda has mainly two agro-ecological zones. “Weinadega” (Mid-land 1500-2000m. attitude above sea level) that constitutes 22% of the total area and” Kolla”

(Dry-low land less than 1500m above sea level) that accounts for 78% the area. (The World FED Office, 2012) from this it is possible to conclude that the majority of the area where the Rural population occupies dry area which is endangered to erratic rain fall that makes the woreda the most drought prone area in the country [31]. The Woreda has drought risk rate of 329 % (World Bank, 2004).

According the World Bank memorandum, the woreda average rural household has 0.3 hectare of and equivalent of 0.5 heads of live stocks. Its 72% of the area is exposed to malaria and to other tropical diseases. (World Bank, 2004). According to the FED office of the woreda there are four health centers, 29, health stations and of standard health posts with the potential health service coverage of the 47% based on the same source, in 2011there are 10 Health Offices (1 HO per 28871 people), 81 Nurses ((1 Nurse per 3565 persons), 12 lab. Technicians,(1lab. Tech per 24059 persons) 82 Health extension workers,(1 H.E.W per 3498 persons 1 (WFED Office 2012). Hence, one can understands that the health service coverage in the woreda is very poor even which has no a single medical Doctor for the entire population.

The research was conducted into two purposively selected peasant associations (Kebeles) that the researchers believed they are appropriate the main objectives of the study. This selection was based on the two reasons. The first reason is that both kebele have health centers where malnourished children and their respective mother's receive health services. The second is that the Yirba- Duuwancho kebele peasants association, that is located in the central part of the woreda, and the Belila-Medolomukeanqa kebele, in the north west of the woreda', which are centers for the most drought prone areas compared to the other 111 kebeles in the woreda with total population of 31426 and 6725 households.

2.2. Methodology and the Research Processes

2.2.1. Methodology

Before promptly deliberating the specific methods and techniques that were used in generating useful data in this research, it needs to discuss and overview some major methodological discourses and make clear what kind of the research approach we preferred to conduct i.e. whether qualitative or quantitative or mixed. Because, as Dawson C. [5] stated methodology and method are different in research that the former is the philosophy (approach) whiles the latter is the tool of gathering data.

With their respective merits and demerits there are qualitative and quantitative research approaches. Dawson C. [5] has comparatively defined the two approaches in such a way that 'qualitative research explores attitudes, behavior and experiences through such methods as interview, observation and focus group discussion. It attempts to get an in-depth opinion from participants. As it is attitude, behavior and experiences which are important fewer people take part in the research, but the contact with the people tend to last a longer.' Based on this definition we can see that qualitative approach is advantageous in terms its quality in digging out facts from primary sources about human experiences, behavior and attitudes which are difficult to dig out in the same level empirically or quantitatively. Other merits of the approach are its small size study population and its in-depth understanding of the cases. While in terms its demerits this approach needs prolonged time duration and needs intensive investigation of the group's life under study in to which the researcher needs to be its part. On the other hand, Dawson C. also defined quantitative research approach as 'that generates statistical data through the use of large-scale survey research using methods such as questionnaires or structured interview. It researches many more people, but contact with those people is much quicker than it is in qualitative research' (2007). According to this definition this approach needs more people size to study large-scale societies and it is more objective which can be considered as its merits. Its disadvantages include its resource consuming nature and being not in-depth in to which the observation takes place based only on the value and meaning of the observer where the observed plays passive role. Finally Dawson concluded that 'neither (of the two) is better than the other, they are just different and both have their strength and weakness'.

Hence, in the light of this methodological debates and varieties our research was mainly inclined to the qualitative research approach to generate basic facts from primary sources. This inclination of our research methodology can be justified with three fundamental reasons. The first is related to the content of our inquiry that is studying the influence cultural context upon the nutritional status of children and mothers in the study area. Then, our basic variable, "culture refers to the learned, socially acquired traditions of thought and behavior found in human societies. It is socially acquired life style that includes patterned, repetitive ways of thinking, feeling and acting". [11] Accordingly, this directly requires the in-depth investigation on the behavior, experiences, thought and belief the group studied towards the problem. Hence, these variables, we thought, exactly fit to the merits of the qualitative research methodology. The second reason is the concern of our specific research questions. The research questions examined in this study are those mainly inquiring the question how the culture of the people in the study area affects the nutritional status of children and mothers, but not to what degree or level which is quantifiable. The final reason behind the selection of qualitative approach is that the research was conducted in relatively small sized and homogeneous social group which is precisely compatible to the method.

However, with the limited degree the research was also utilized quantitative method of research. This was specifically to deal with secondary data from concerned offices and institutions to investigate the current prevalence and situation of the problem studied in the study woreda as well as the level of actual efforts to alleviate it.

As result, the main theoretical framework of the research was based on discourses of the grounded theory of research that emphasizes on the generating of theory or generalization which is grounded on the data i.e. inductive logical reasoning.

In general, the research methodology should be conceived as the mixed approach with limitation that mainly based on the qualitative research method. This helped the researchers to triangulate the facts discovered from each methodology which increased the validity of the findings.

2.2.2. Methods of Data Gathering

To address all the research question properly and inconformity to the types of data required to the study, the researchers had made fieldworks in two phases, the firs during June and the second during October 2012. In the course of both fieldworks variety of qualitative data generating methods, such as observations, interviews and focus group discussions, were utilized to the level of attaining in-depth understanding of the meanings, values, norms, behavior, experiences, social status and the livelihood of the people studied in relation to the malnutrition (Under nutrition) of children and their mothers. In what follows, the types of methods (tools) used in data collection the types of information acquired in each specific method will be presented.

2.2.2.1. Interviews

During both sessions of fieldworks variety of interviews have been made as one of the main methods of data gathering for understanding peoples knowledge, belief, experience, opinion, values and meaning they have towards malnutrition (under nutrition) of children, pregnant and lactating women in the two study communities. Because interviews are particularly well suited to collect in-depth qualitative data about the individual's and group definition, belief, feeling and practice regarding the problem. Accordingly, based on the interview schedule (Appendix 1), numbers of interviews have been made with the informants selected with the snowball purposive sampling techniques either individually or in a group in fair and equal frequency as well as distribution in both study sites. The processes of interviewing were facilitated either by the researchers or by trained enumerators. The participants both in the individuals and in group interviews were selected based on variety of variables related with the objectives and basic questions of the research which includes pregnant and lactating women those who were suffering from malnutrition (under nutrition), mothers who had malnourished child, household head husbands of the family with the problem, the community elders, health post workers, religious leaders, aid delivery program workers were among others.

Picture 1. Researchers interviewing in the Yirba-Duuwancho kebele

Individuals Interviews

Many individual interviews were conducted with the people assumed to be relevant to the study who were selected because of their important status, knowledge and role in relation to the inquiry of the study, by the virtue of which they were selected to be informants. These include:-

Elderly people: From both study sites two elderly and knowledgeable persons (from both sexes) were interviewed as the key informants to long and repeated interviews that managed under multiple visits. With the discussions made with the informants many important issue were held regarding the community's cultural (emic) belief, definition, knowledge, value, and norms towards pregnant and lactating women; the cultural behavior and practice of the people for those people such as pregnant or lactating mothers and children (under five years); the existing folk understanding and special treatments available to lactating and pregnant women and their respective child. Also, about the social structure and gender power hierarchy within the households and about the society's norm of the food habit, classification and taboos were discussed. Food consumption, distribution and priority in the households were among the others. There were also in-depth discussions regarding marriage patterns (polygamy or monogamy), household population (size) policy, child rearing practices, and personal hygiene of the society.

We also conducted separate discussions with our female informants (one from each community). These special discussions were held on issues such as gender role and status within the households; socially constructed rights, obligations and expectations of a woman in the family when she is pregnant or lactating. The cultural norms the decision making power of women on economic, social and even medical practices. The birth and initiation rituals of the society were also the points we discussed. We also discussed about culturally defined body image of a child and mothers, which the group believed to be normal.

2.2.2.2. Focus Group Discussions (FGD)

In the course of the two fieldworks six focus group discussions were accommodated. The main groups with which the discussions run were malnourished pregnant and lactating mothers, mothers with malnourished child, household head husbands from families with the problem, the kebele health post workers in the study sites, government relief aid delivery workers, religious and the elders of the communities. The FGD with the two groups of mothers were held at the compound of the Yirba Health Center, the woreda capital, where mothers from both the study sites were collecting their monthly rations which distributed as cure from malnutrition (under nutrition).

Each of these FGD's was discussed on separate issues that specifically concern the group from the topics in the interview schedule as it is summarized in the appendix 2. (See Appendix 2)

Picture 2. one of FGD conducted at Belila-Medolomukeanqa kebele.

2.2.2.3. Observation

Observation is the very effective way of finding out what happened in practical contexts, the routines and interaction patterns of the every day's lives within the communities we studied. It can provide the understanding of what is happening within a family or the community in actual practice and behavior. Obviously the people who know that they are being observed may alter their behavior or practice in all sorts of ways. To minimize such disappointment in our investigation, both researchers were created rapport with the families and groups observed, this was partially because all observations were conducted during the second phase of the fieldwork for which the first created a friendly context. And it is partially because one of our enumerators was native for the study area. Also our interviews conducted earlier have given us opportunity to find out what and where to be observed in the observations held latter.

In both study areas we accomplished frequent observations on families' day-to-day life experiences in variety of contexts such as in daily meal serving occasions within families, household labor activities both in and outside of the houses, the workloads and responsibilities of pregnant and lactating mothers, and the preparation and content of the household staple food. Also we attended two birth giving rituals whose mothers were suffering from malnutrition during pregnancy. And we were participated two rites of initiation where child circumcisions were taking place. However, during all processes of observations the researchers remained as observers as participant with the degree of passive participation.

In aspects of the observations the focus of our intention was to dig out relevant information on the following basic points of the research that made clear our understanding about the actual behaviors in the study areas. These include:

- The role and status of women in the actual context of a households
- Culturally constructed rights and obligations of women in resources and other daily social interactions
- The priority, opportunity, expectation and challenges for the lactating and/or pregnant mothers within the households.
- The family food (meal) variety, usage, habit, priority and distribution privileges among its members.
- The culture of hygiene and sanitation in and around family environment.

On these and some other specific points, we strongly believed that we get very wide insights which enabled us to understand the actual reality that was pertinent to our investigation on the subject we dealt in the area. In general all the methods we utilized and discussed above were tools we intentionally selected to explore qualitative data from primary sources. In what follows the discussion on how we collected quantitative data from secondary sources is presented

2.2.2.4. Secondary Sources

In order to attain the research demand to depict the contemporary recurrence, distribution, and prevalence of the problem of malnutrition on children (under five years), lactating and pregnant women in the study area, we attempted to find out and investigate unpublished reports, records and other archival documents from the Woreda public health office, government health centers and the kebeles health posts.

To portray the existing efforts of the government relief and aid programs towards alleviating the problem of malnutrition in the area, we utilized unpublished records and reports from the woreda Disaster Prevention and Food security office. By doing so we found data about the number of beneficiaries, the allocated resources, and the level of malnutrition in the woreda during recent period.

Much effort was also made to look through the published census reports from the Central Statistical Authority (of Ethiopia) to find out data about the demographic characteristics of the society studied. However, we attempted to check the reliability of the data gathered from the secondary sources before directly using them as evidence. In doing so, we cross-checked the data with what we observed during our fieldworks.

2.2.3. Methods of Data Analysis and Presentation

Based on the qualitative data gathered through variety of methods, data analysis and presentation were carried out in such a way that let us to properly address the research questions posed in relation to the influences of culture on the nutritional status of children and mothers in the rural households where the research have been conducted i.e. this was the central theme of the study to investigate culture in its holistic structure.

Because of the qualitative nature of the research, individual interviews and FGD's were tap recorded which were transcribed just a little while after the end of each sessions in the field and from which findings were also categorized under different codes. These codes and categories were focused some relevant points such as cultural practices, culturally defined roles and status, life styles, the traditional beliefs and social contexts, gender stratification and power were among the others. Based on these codes and focus areas, the findings were interpreted, described and presented from both the "emic" and "etic "points of views.

Observations conducted repeatedly were recorded in our field notes daily on the study area. This method was important and competent because beyond recording facts it was helpful to understand and remind the meanings and feelings of the group which were critical to interpretation and describing.

In general, in our research processes the data analysis were on-going processes which took place simultaneously throughout the data gathering processes in to which we thought and discuss upon the emerging issues that some time caused changes on our existing methods and inquiries. In this way at the end of data gathering all data were described, interpreted and presented for the final assembly.

3. The Literature Review

For our study purpose the review of literature consists two main sections that the first deals with the basic concepts related with the objectives of the research. The second presents already studied findings on the related issues in the Ethiopian context.

3.1. Human Food and Culture

Besides its biological and universal characteristics, human food is an aspect within the totality of human cultural system. What distinguishes the anthropological study of food from that of other disciplines is its focus on food within cultural and cross-cultural context. It attempts to situate the study of food within culture or community seeking to explain the interrelation between food system and human (group) behavior. Hence frameworks to the study of human food system must not be limited only to its economic, environmental, natural or the like. But it must include the political economy, cultural ecology, equality, gender, ethnicity, social and cultural hierarchy and food as the group identity. [19] Therefore, it is in line of this perspective that this research has intended to approach the subject.

In all human society food plays many roles and it is deeply patterned in the social, economic and religious aspect of everyday life. In every human society it carries wider range of symbolic meaning that expresses and defines the relationship between man and man; man and deity; man and the natural environment.(Ibid)

Food as a culture reflects the group identity that one cultural differs markedly from another in many of their belief and practice related to their food in terms of:

Regarding what substances are food and not food

Regarding the rules and norms of the group that governs who prepares, serves and manages

Regarding to whom what kind and amount of food should be served [3].

Human food also symbolizes social status; usually b serving rare and expensive dishes people express their value and rank them are giving for the person participating on the meal. According to Jeliffe D.B. [16] "It is prestige food which is usually protein (often animal) difficult to obtain or prepare (as they are rare, expensive or imported) are linked historically with the dominant group members in the household."Hence it is not the biological necessity that determines what to be served to whom but culturally constructed norm and socially defined status of the members with in the household.

During the time of special and natural physiological changes in human body there has to be certain rearrangements on the food intake. Physiological states like pregnancy, lactation, menstruation and childhood need certain foods to be avoided or eaten. Since such prescription of food is also culturally patterned, it may have negative effects on the physiological status and process of the individual, including the nutritional status.(Ibid)

While the primary purpose of food is nutrition, it also has cultural dimension by which the members of the cultural group choose what, when, where, how, who to eat not only by flavor or its nutritional value but by many cultural factors such as religion, gender, economic and social status, ethnic and kin relation. (Ibid) From this it is possible to argue that the nutritional status of a household and/or its members is not only determined by the biological (nutritional)content and availability of the food, but also by the cultural patterns that governs the food norm, custom and value within the community at large. This is an angle from which that this research is looking on the problem.

At the household level,' who eats adequate 'and 'who does not' during food scarcity crisis is a matter of decision making that has much to do with intra-household power relation' [28] Then what determines the power relation within a household is the culture of the larger group or the community that defines 'who has to eat adequate or not'. Hence, those who culturally preordained to inadequate variety (calorie) with in household are vulnerable to malnutrition. Based on this premise it is possible to assume that even in the time of food security or full relief aid coverage there can be persistent malnutrition among those members of the household simply because of the cultural factors what this research attempts to investigate with the special concern to children and mothers.

3.2. Culture and Malnutrition

In all human societies, food is eaten for both cultural and nutritional ends. But the former influence the latter in to two ways. On the one hand culture may prohibits much needed and nutriment substances from the diet by defining them as non-food, profane, alien, lower or higher class food, taboo etc. And on the other hand culture may encourage certain foods and drinks by defining them as sacred, food medicine or as a sign of social, gender, age, religious or ethnic identity, which are harmful and injurious to health and nutrition. [17] Hence in a society where both types of influences are persistent there will be an increased risk of malnutrition at the households where there are children and mothers being needy for more nutriments simply because of their critical physiological status.

There are other cultural factors that have indirect effects on human nutrition. These include among others

- The cultural belief and value about the structure and function of the body, its standard size and shape
- The cultural belief in the role of food on health and diseases.
- Culturally defined role and norms of food usage and distribution within the family among its members.(Ibid)

In her study on child malnutrition in Mali, Dettwyler described variety of interconnected factors. According to her, "relative poverty alone can't completely explain variation in diet and nutritional status within a community. And that rising income is not correlated with increase in quality and improvement in the nutritional quality of diet. Therefore, a variety of biological, cultural and social factors have contributed to the child's poor growth" [6].

Another interesting issue, which has triangulated effects on nutritional status of both the child, pregnant and lactating woman, is the cross-cultural nature of infant feeding and lactation. The care and infant feeding are universal human phenomena but there are cross-cultural differences in the technique, type and frequency of the practice. According to the findings of the World Fertility Survey of 1984, the rural women in those countries (42 developing countries) breast feed on average of 2 to 6 months longer than their counter parts in urban counterparts [14] Hence this shows that the more breast feeding mother needs the most nutriment food. Then the question is that is there such kind of selection of food stuffs in the rural parts of our country?

In every community there are varieties of factors that influence for how long women breast feed their infants

which can be cultural, social and economic. There is also culturally determined emic understanding about how they explain failure to breast feeding to them or to others and when and why they wean infant. However, successful breast feeding mother and pregnant need certain additional requirements on the life style and biological interests such as patience, free time sense of responsibility, healthy state of mind, good luck, specific change and additional variety in diet. [12] Whether such things are there in the rural households in rural Ethiopia?

3.3. Food security and Food Insecurity

A household may follow a type of strategy and practice certain activities that may leads to either to sustainable (desirable) or unsustainable (undesirable) outcome of livelihood. Poverty and food insecurity are among the outcomes of unsustainable livelihood. A household that leads sustainable livelihood often feel food security on a continuous basis. …..This capacity to sufficiently feed household members- both in quality and quantity – leads to a more security and healthy life. Conversely, food insecurity refers to the situation when the household is unable to sufficiently feed its members either from its production or from market. A household that can face food shortage problem when only hit by disaster or shock can be referred to as temporarily food insecure as the result of which number of adults and children encounter severe malnutrition that contributes to in outbreak of various epidemics and mortality [28]. Then it is such condition that our research attempts , investigate.

What food security is and how it can be improved are widely debated and mach confused. Part of the problem is that the concept is concerned with interconnected domains; with question of agriculture, society, environment, employment, market, health and nutrition and policy. [24] At this point this research assumes that the cultural domain is also among the determining aspect of inquiry. Based on such debates there are different definitions:

According to the food and agriculture organization (FAO) food security means ensuring that all people at all time had both physical and economic access to the basic food they needed (FAO:1983). The World Bank (1986), EU and other western organizations are sharing similar conception with certain specifications on the level of study. However, the issue surpasses beyond satisfaction of food because the concept 'satisfaction' itself is culturally patterned and cross-cultural that needs specific study based on the spatiotemporal contexts.

3.4. Measuring Nutritional Status of Children and Mothers in Ethiopia

Literatures regarding catastrophic famines in Ethiopia seems to be voluminous Nevertheless, proper transitory(recurring) food insecurity has received little attention, despite its prevalence even in what we call 'normal years' as well as in the so called 'high potential' and 'surplus area'. [29] At this particular conception, it is logical to argue that not only the case of food insecurity but also its grand effect child –malnutrition-on children, lactating and pregnant women has gained littlie academic attention except relief operations.

In Ethiopia, only 49 % of lactating women breastfeed for the first six months and in addition child malnutrition is linked to limited health service, inadequate consumption of nutrient-rich foods and poor care resulting from cultural traditional practices [31].

Based on the above facts measuring malnutrition is empirically defined as 'all children between 6 to 59 months with MUAC (Mid- Upper Arm Circumference) of less than 12 cm, and all pregnant and lactating women with MUAC less than 21 cm are referred as malnourished. These 12 and 21 cm cut-off points for children and lactating and pregnant women were decided with stakeholders in the Ethiopian nutrition community. (Ibid)

Based on these conventional screening standards, the relief operations in the country allocate for each household member approximately 200 kcal/person/ a day. Because of their biological and physiological behavior, children under 5 age, lactating and pregnant women are expected to have additional calorie with targeted supplementary food (TSF) ration in the form of fortified blended foods and fortified blended oil with the aim of minimizing the nutritional gap between individual's actual consumption and their additional nutritional requirements. (Ibid) The central thesis of this research is, therefore, even with such and other humanitarian assistances and efforts, why the nutritional status of children (under 5 age), lactating and pregnant women remains within the malnutrition circle for long period with in a household? Then, the researchers assumed that there has to be strong influence of the cultural context behind the problem under investigation that may be cross- cultural.

3.5. Impacts of Under-nutrition on Children and Mothers

In most cases of child malnutrition (under nutrition), in the rural areas, it can't be understood apart from the poor treatment and care of the child's mother both during the state of pregnancy and of lactation. Because child malnutrition might be the upshot of untreated and uncared mother. According to Nebiyu M. [23], Child survival in large part depends on the women' health, nutrition and survival. Poorly nourished mother are more likely to have pregnancy and obstetrical complication, to have an infant with depleted nutritional reserves that are required for brain and cognitive development, immune function and adequate body growth and development. Hence, from this argument it is possible to conceive that the nutritional status of a child largely depends on and resulted from the nutritional status of mother during the time of her pregnancy and breast feeding.

What so ever its cause should be, malnutrition (under nutrition) has combined effects that cause infectious diseases which are common in sub-Saharan Africa such as malaria, measles, diarrhea, pneumonia and the like. Malnutrition aggravates the frequency and severity of such diseases which needs more health services. Even the case remains worst in areas where there is no appropriate health service and treatment. (Ibid)

In its long term effect malnutrition leads to uncomfortable level of diseases and deaths, poor school performance and retarded mental and physical performance. This situation has also indirect impacts on socio-economic development at large because good nutrition is a pre condition for rather than result of human and economic development [12].

It is now recognized that 6.6 million out of 12.2 deaths among children under 5 years age or 54% of children mortality in developing countries is associated with malnutrition. [27] Therefore, malnutrition in all its consequences has great deal of negative impacts on the human physical, mental, economic and social aspects.

3.6. Basic Factors of Malnutrition (Under nutrition)

Under nutrition refers for the deficiency of important elements as vitamin, protein and energy sources within the body of human individuals. [3] Then it is a sound to ask that why a child is in such state of deficit? The right answers for the question rest up on both the condition of his /her mother and /or the socio-cultural context where the child lives.

Different scholarly studies have found out multi-facet influence which effect child and mothers malnutrition. Nutritional status of children and their mothers is a manifestation of a host of factors including a household access for food and distribution of the available food with in the household, availability and utilization of the health service and care provided [23]. According to the international conference on nutrition, causes of malnutrition can be classified in to three categories: the immediate and basic causes. The immediate cause includes poor and inadequate dietary intake and infectious diseases which are resulted due to their underlying causes such as insufficient food accesses for food, child care, water supply and environmental sanitation. For all these causes there are basic causes such as political, economic and social factors.

There are also variables such as level of women's education, national per capita food availability, health and environmental factors are considered as determining factors on the status of malnutrition. Mothers' health knowledge and marital education emerged as the key elements of an overall strategy to address malnutrition [25]. This can be seen as an indicative that assures the strict relationship between malnourishment of a child and her/his mother.

Number of researches and surveys identified variety of determining factors of malnutrition in Ethiopia. According to one of the surveys in 1998, poor socio-economic background, poor housing, the absence of latrine, unprotected water sources, incomplete immunization, prolonged breast feeding and nutritionally inadequate diet are said to be causes of child and mother's malnutrition [32]. Others also identified demographic variables such as length of preceding birth interval, age of the child, number of under five years children in the household are determining factors for malnutrition. [10]. Household resources, parental education, food prices, maternal nutritional knowledge considered as influential factors for child –mother malnutrition [27].

However, all factors pointed out manifest the epidemiological point of view that is based on the measurable empirical facts (data). But the problem needs to give attention from the ethno-medicine perspectives that views malnutrition as an effect of cultural thought, belief and practice.

3.7. Child and Mothers Malnutrition (under nutrition) in Ethiopia

For long period of time, Ethiopia has experienced consistent preschool child and mothers malnutrition problems, with malnutrition ranking amongst the worst in sub-Saharan Africa. While this has been sufficiently documented by the case studies and national official surveys. The reasons behind it are still poorly understood. More than quarter of children born do not reach the age of five years; this is the fifth mortality rate in the world [1].

Child and mothers malnutrition is among the most serious public health problems in the country. Result of the 1998 national rural nutrition survey indicated that about 64% of all children aged 6-59 months in rural Ethiopia and 37% of their respective mothers were chronically malnourished. The level of acute malnutrition in these children and mothers was 8% and 12% respectively and underweight were 47% of the children. This prevalence of underweight is likely to be the highest in Africa [32]. From these findings we can deduce that there is strong nexus between children and their respective mothers and the study of the one needs the investigation of the other because each problem has reciprocal connection with the other.

The level of stunting was 52% in the SNNPR among children aged under five years. Household survey conducted by the SNNPR during non-famine time, showed that rate stunting and underweight in the region was 48% and 42% respectively and wasting found to be 11% [26]. More over this finding indicated that, no program carried out or institutionalized in health facilities concerning assessing nutritional status except growth monitoring during vaccination. This statistic shows an alarming situation and even situation is expected to be more serious in the region. (Ibid)

Regardless of all these difficulties regular academic intervention on the problem is not frequent except the preventive efforts or biomedical actions especially during the recurring humanitarian crisis. Even there is no regular and frequent assessment about what factors are there behind the problem that copes with the dynamic nature of human socio-environmental context.

3.8. Biological versus Social Perspectives on Pregnancy and Lactation

All scholars, irrespective of their disciplinary differences, share belief about vulnerability of the body of pregnant mothers and their fetus during pregnancy, to some extent this extends even after birth especially throughout the early postpartum (after birth) and lactation periods. [3] However, common understanding becomes parallel when variant disciplines explain and analyze the cause, the nature and the remedies of this condition of vulnerability. Because, while biology search it from the natural and behavioral angle as the state of an individual being, social science look on it from the social and cultural angle as an aggregate effect of the group behavior and thought.

The Physiological status of women during pregnancy and breast feeding place enormous demands as it builds tissue and these conditions requires an increase in protein, vitamins, fat and carbohydrates consumption and also more leisure than the normal condition. Experts recommended that pregnant and lactating women to consume 55 and 65 grams of protein per a day

respectively to maintain their health which is 45 and 65 grams per a day for women in the normal state of being. They also need the same proportion of others nutrients. Also malnutrition commonly associated with dietary deficiencies, it also can develop in cases where people have enough food to eat, but they choose foods low in essential nutrients [27]. This makes clear that mothers in the state of pregnancy and breast feeding need to have selected and special food varieties rich with the necessary nutrients. Then, despite the overwhelming poverty in the households of the rural Ethiopia and strict patriarchal social structure, is there possible and practical prospect in the rural Ethiopia to give priority to pregnant and lactating women? This is also another thematic question that the research attempted to answer. In most culture, including bio-medicine, it is believed that the mother's behavior, i.e. her diet, physical activity, state of mind, use of drink, drags or tobacco- can directly affect the physiology of reproduction and causes damage to the unborn child [3].

According to social sciences point of views, pregnancy and child birth are more than just biological event. They are social phenomena that mark transition of woman (especially with the first birth) from social status of woman to mother (Ibid). Also Homans H. [13] states the same reflection as 'pregnant woman is in the state of transition between two ambiguous social roles; those of being wife and mother. In this state where she is neglected considered as being abnormal, vulnerable to outside danger, sexually abnormal and some time dangerous to other people (contaminated)" Even in some non-western societies Homans H. argues that pregnant and lactating women withdraw from some social activities and subjected to certain diet taboo and behaviors

Anthropologists argue that not only the taboos and restrictions on pregnant women can be explained as protecting both mother and fetus from physical damage, pregnant mother is also in a state of social vulnerability and ambiguity. There are variety of social and cultural factors that are influencing the state of pregnancy and even lactation. These include strong emotional condition, much rest or unrest, excessive and hard work, cultural belief about the uterus during pregnancy. Above all the diet of the mother and its taboo that culturally accepted without considering its nutritional content may directly affects the nutritional status of both the mother and the fetus or the child [17].

Hence, to investigate the influences of the group's cultural influences on the nutritional statuses of mothers and their respective child one has to investigate the social and cultural construction, belief and behavior about the state of being pregnant and lactating woman. In this connection Helman C. G [3] states that "cultural beliefs about physiology, protection and dangers of pregnancy and lactation have social, psychological, and physical aspects. The group members perceived her as a special category person surrounded by what their culture tells them are protective taboos and custom. This helps to explain any physical and mental harm on mothers and new born children or unborn fetus"

4. Result and Discussion

4.1. The Prevalence of Malnutrition in the Study Area

This section depicts the existing condition of the state of malnutrition in the study kebeles, which helped us to understand the frequent and persistent nature of the problem even variety of governmental and non-governmental organizations have been working on it. The discussion follows from the table (Table 1) that is modified from the monthly report of the Yirba Health Center on severe malnutrition, from which the researchers purposefully selected data of the malnourished children and mothers from the two study kebeles. And figures in the table covered eight months admissions from May to November 2004 E.C. which gave the chance through the problem within variety of agricultural seasons.

Table 1. Report on Management of Severe MN- therapeutic Feeding program

	May		June		July		August		September		October		December		November	
	A	R	A	R	A	R	A	R	A	R	A	R	A	R	A	R
Children <5	14	6	17	7	15	8	9	4	6	5	12	4	18	9	21	11
Pregnant	7	2	5	1	6	3	3	3	4	2	8	2	10	4	13	5
Lactating Mothers	11	7	8	3	13	5	7	5	5	3	8	2	11	5	14	7

(Abbreviations: - **A** Refers for the total admissions at the end of each report month, **R** refers the total Relapsing cases that previously were cured bet returned back with the problem.)

The figures in the table showed that out of the total admissions of severe malnutrition cases throughout the report months (245) the 45 percent (112) was the admission of children, while the 31.4 percent was that of the pregnant mothers and the third rank 22.86 percent was covered by lactating mothers. Accordingly, from these data we can conceive that the most affected and vulnerable family members of the study society were children under five years of age. The second most vulnerable members were lactating mothers. And the pregnant mothers were found to be relatively less affected. However, the data indicated the higher level of frequency and prevalence of the problem in the study society. Because the data can only represent those people suffering from severe malnutrition and it is possible to expect many other people suffering from acute and moderate malnutrition as well as those who didn't came to the health centers. From this one can understand malnutrition as one of the critical problems exerted on the households of the rural areas.

The comparative description needed to be made between the eight report months based on the two variables in the table i.e. Total admissions at the end of each month (A) and number of relapsing cases (A).

Admission cases in all the three groups had reached at its climax during the last three months of the report period (October, December and November). While lesser figure of admissions have been reported the three Ethiopian summer months of the year (July, August and September).These seasonal groups of months, in the Ethiopian agricultural society in general and the Sidama society in particular, have variant characteristic features. On the one hand, from late July up to the end of September the rural agricultural families of the study communities are relatively in the state of relaxation and rest after the hard and intensive work in the fields that usually took place in June and early July. Also during these months most of the rural households of the study area were facing challenges of food security and shortage of economic resources because they already expended their potentials for seeds and agricultural outputs. However, the situation was paradoxical that when the people were in the state of relative rest and of scarcity of livelihood, the prevalence and frequency of severe malnutrition had been reportedly declined. Therefore this justifies the fact that when the people were getting rest from intensive work load they would give more attention and care for their needy members of the family like children, lactating and pregnant women even with scarce livelihoods. That is shortage of livelihood alone can never necessarily leads to malnourishment.

Equally paradoxical relationship, on the other hand, founded that during the last three months of the report (October, December and November) the farmers of the study area were highly occupied with the labor of harvest even most of them were passing some nights in their fields. It was a period that needed the participation of every able house member in collecting harvests including children, a period when nobody cares about another member of the family. Also during this season no household suffer food and resource insecurity. However, even food was plenty and resources were available, the rate of admission of severe malnutrition reached at its climax in the study area. Hence it was vivid reality that scarcity or availability of livelihoods alone can not necessarily determine the rate and prevalence of malnutrition, but the social and cultural contexts of the households also have triggering impacts.

Another point that was deduced from the data in the table the relapsing cases of severe malnutrition that those patients who were previously cured and sent home with additional blended foods which sustains their condition, but returned back with the problem. During every months of the report, almost 60 percent of the cured individuals during the previous month were returned back to the therapeutic feeding center at the Yirba health center. According to the health professionals, who were participated in one of the FGDs, the main reason why the cured patients were returning back was misuse of the prescribed food medicine at home which contains very nutrient-rich elements to the patient that help her/him to be cure acute and moderate malnutrition. This misusage, according to the informants, can be seen from two angles. On the one hand, the prescribed nutrient-rich blended food and refined oil were primarily were served for the husband in the household which culturally defined 'normal behavior' of the wise wife. On the other hand, the remaining portion, of the food also needed to be shared with other children of the extended family. As the result the patient remains untreated and relapsing of the cured problem became persistent

Hence, from this we can see that the recurring and persistent nature of malnutrition couldn't be explained in terms of access for resources alone that even the access is available there can be the recurring malnourishment due to misuse of the available access because of the cultural and social beliefs and practice.

4.2. Food Culture, Habits and Malnutrition

Food culture of a given society is a broad concept that determines how food is produced, prepared, stored, preserved, distributed and consumed with in a household. It also comprises the belief, behavior and value that the group has about the variety, norm, usage and context of food different foods. Food culture or habits explains whether there is any bias in how proportions of food are allocated in the type food prepared at a household at a given time. In this section, therefore, we described the findings in such and other contexts within the study communities.

Unlike other most Woredas of the Sidama zone, the Boricha Woreda and also the study Kebeles are non-coffee producer areas, which is cash crop in other areas. The main agricultural products in the study communities are production of crops and cereals such as maize, wheat, sorghum, barley are among others. Even unlike highland Woredas of the zone, where Enset (false banana) is the staple food of the Sidama society, the study community is not the one that produces it because of unfavorable lowland and hot climate of the area for the plant. During the rainy season of months from May to June the study society produces variety of edible root and tuber vegetables such as potato, sugar cane and some other endemic variety of root vegetables which are usually consumed during the summer season when other crops are scarce. According to our key informants and the FGD made with the relief aid workers, the society's food security in summer will be at risk if the rain missed during May and June which increases the prevalence of malnutrition cases because it implies that there is no root vegetables which highly important for the household livelihoods at that time. Another rare and expensive source of food in the study communities is the domestic edible animal products such as milk and its products and meat. However, the consumption of these varieties of animal sources is rare and they are usually served during special occasions such as rituals, religious holidays social, ceremonies and when respected gusts were coming to the house. One of our key informants has said that, "I will kill a ship or a got when my son-in-law or one of his patriarchal descents is coming to my house, because either of these is the very respected and ranked visitor of our community". From this conception we can understand that animal product food varieties are believed to have top ranked status not only because of their rich nutrients but also because of their social value. That such foods symbolize social status, usually by serving rare and expensive dishes people express their value and rank they give for the person participated in that meal. Hence, the frequency of getting such nutrient rich variety for the children (under 5), pregnant or lactating mothers was rare and even challenging which might contribute for their

under nutrition cases. Because, these prestige foods, which usually protein and difficult to obtain or prepare, are linked socially and culturally with dominant patriarchal group in the study communities.

The role of production, preparation and serving, in the study communities are reflecting the social and cultural system of gender division of labor. The role of cultivating and harvesting food crops and cereals, which are accomplished out in the fields, dominantly performed by and under absolute control of the adult male members of the family, however during intensive work loads adult women also participate on the duty. This occupation that is socially reserved for male members of the family, according our informants including women, believed to have higher prestige that needs higher reward and respect which reflect itself with the absolute power of the husband on the economic and social affairs of the household. The domestic role that is preparing, serving and cleaning afterwards culturally and socially the responsibility of mothers and her adult female children. Preparation of daily food for the family presupposes collecting fire woods from the nearby forest, fetching water from far streams, cleaning utensils, splitting fire woods, cleaning the house and so on. However, the day long labor of mothers and their restless domestic activity were not considered as a part that contributes for the livelihood of the family. According to the discussions held with pregnant and lactating mothers themselves, their work loads, compared with their counterpart, are inferior because they can't have any economic contribution for the family. This notion also supported by our key informants in both study communities. From such beliefs it is logical to deduce that gender based labor division created the belief on the inferior status for the role played by mothers who led them to lose power on decision making in the family affairs such as on health care, on food preference and distribution that has direct effect on their status of malnutrition.

The typical staple food of the Sidama people in the study area is tima (local bread made from maize flour) which is eaten with shna (cooked cabbage soup). This was mainly because the dominant agricultural product in area is maize which became the habitual food source of the community. Beside tima there are occasional food varieties made from potato, sugarcane, godere (local potato) and the like. Unless certain special holidays or ceremonies took place, there were no frequent and planned consumption foods varieties which contain protein and fat contents. Because the mentioned varieties of the people's staple foods mainly consist carbohydrates and vitamins. As the result, the society's food habit and preference were incomplete dietary content which aggravate the prevalence of malnutrition on children under 5, lactating and pregnant women whose physiological conditions demand even more. The relief aid workers in the FGD had confirmed that their office monthly distributed cereals such as wheat and sorghum, refined oil, blended foods and milk powder (for children), but the targeted groups usually had sold these items in order to purchase maize in exchange.

Concerning the cultural pattern of eating in the community studied, there were no the standard three patterns eating the daily bread. There are only two meal times: shoomaancho (breakfast), that will take place in the morning before leaving out to the fields) and barrihurbaate (dinner), that take place just after the castles are getting in to the house). The meal usually was served based on the sex and age categories. The father of every house consumes independently, but if there is an older son with above eighteen years of age he may accompanied his father. All children below adolescence are given meals on the same utensil, where the younger one usually been attacked by the elder. When serving the meal for the two groups' ends, the meal of the mother begins that in most cases her dish might includes the surplus from the previous dishes. As we observed in one of the houses in the study area, early in the morning about 6 AM, the pregnant wife of the household and her small daughter were busy to prepare and serve the best breakfast for her husband who is still on the bed, which was the day's number one duty of the best wife. Then, after serving her husband with tasty dish of cheese, she started making coffee and preparing loaves of homemade breads of maize (beaked last night) to be served for the rest of the family members including her malnourished child and herself. This was breakfast for the pregnant mother and her malnourished child under 5 years of age. As one of our female informant reason out this instance, priority should be given for the husband because he is the head of the house and that if the house once lost him it is shock for the family, but a child can be replaced by another new born. Hence, gender stratification in the community was not only creating hierarchy within the households but it influences the nutritional statuses of the pregnant and lactating women and children, because these are groups with the need for additional and variety of rich nutrient foods. Moreover, the cultural food pattern and distribution, therefore, may contribute for the decline on the malnutrition status of children under five age and mothers who were in need of frequent and enough food consumption. Because children who were eating with others matured meets would never consume equal proportion of the food provided with the same utensil.

4.3. Child Care and Raring Practices

Giving care for and raring of a child are universal phenomena for every human groups up on which the overall physical, psychological and social status of a child depends on. These practices include the provision of food stuffs, the ways and techniques of feeding (breast or bottle), the rituals carried out after birth such as circumcision, the level of physical and emotional abuses, the option and practice of taking a child to health facilities who is ill or in need of vaccination. Hence, the research investigated all these main aspects to explore whether they are influenced the nutritional status in the study groups.

4.3.1. Breast Feeding Practice and Lactating Mothers

According to the discussions conducted with mothers and also as all key informants were justified it, unless due to certain biological inability on the mother, breast feeding is culturally approved way child feeding. With cross-individual variation on the frequency and duration of feeding, all mothers were told us practicing it. However, there were variations on the how long breast feeding continued and at what age of the child additional food stuffs provided.

In order to make comparison between what biomedicine prescribed as normal breast feeding practice and what the emic (cultural) behavior actually performed in the community, the research compared data from the two sources. These were data from the FGD with the health professionals and the discussions with the study society.

There were norms and principles that biomedicine prescribed as the ideal way of caring and feeding a child under 5 years of age which were written and posted on the notice board of the Yirba health center with intention of creating awareness. These norm and principles were included the followings:-

- In every session of feeding, each breast of a mother should be sucked until it is empty after which another one should be done in the same manner.
- Children below 6 months should only be delivered with the milk of their mothers without additional foods
- Children from 6 to 12 months should be served additional supplementary foods three times per a day besides 8 to 10 times breast feeding.
- Children from 12 to 24 months need to have four time meals per a day besides 8 to 10 times breast feeding.

In light of these biomedical conventions the research had investigated the emic perspectives and practices based on the data gathered from the three FGDs with mothers who consisted 21 (each 7 mothers).

All the participant mothers confirmed that they were breast feeding their children and all stated that the frequency depended on the availability of milk in their breast. One of the mothers said and all agreed on the notion that, "*Qonsaancho* (adequate breast feeding) is the gift of God which only the blessed mother can be successful" and they added that if the milk (breast) is there we feed our child for not more than three times to the maximum for any age of the child. Hence it was logical to conclude that the traditional frequency of breast feeding practice in the study communities directly contributed for the under nutrition of the children under five years of age because it below the normal description biomedicine. The belief on success in breast feeding on God directly affects the possibility of getting enough breast milk through improvement of diet and physical conditions of the mother which the belief indirectly had negative consequence on the nutrition status of the child and the mother.

Other issues which had investigated were that of the beginning of supplementary foods for a child and until when the breast feeding continued. These were points of divergence among the informant mothers in the FGDs. According to their reply for the question, 4 (19%) less than 6 months, 15(71%) between 6 to 12 months, 2(9.5%) between 12 to 24 months had breast feed their children. From this distribution we can see that the majority of mothers, in the study communities, breast feed for the shorter period than the conventional prescription. Hence, the group's traditional time table for breast feeding directly contributed for the under nutrition of children under five years of age. Also the reason that given for the shortening of the duration of breast feeding practice was the short time interval between the last born child and conceiving the new one which made impossible for the prolonged breast feed. Because, according to them, when a mother conceives a new infant, even less than a year, she ought to wean breast feeding of the previous child which culturally constructed taboo. Therefore, the un-gaped birth frequency and lack of family planning had had indirect impact on children nutritional status.

4.3.2. Impacts of Complementary Food Habits and Psychological Abuse

According to the female informants in both study communities, just after a child is born un- boiled fresh butter would be inserted through its nose as initiation ritual that believed to clean the child's brain and nasal cavities. Surprisingly, this had been the beginning of complementary food stuffs culturally prescribed within the group as ought to be. Regular complementary food, according to them, begins usually between 30 to 40 days, which is very earlier than that of biomedical prescription. As the result, the time of providing complementary food before 6 months found directly reduced the consumption of breast milk that the child had needed to consume which contributed for the child malnourishment.

Even the standard provision of food per a day for a child prescribed to be above four times, as it is discussed above, the daily two times meal policy of the society had been applicable also for children under 5 years of age. Therefore, the culturally patterned frequency of the meal found to have direct negative impacts on the nutritional status of children in that age.

Also according to our key informants, children under 5 years are conceived as respected and innocent family members who are free from any psychological and emotional abuses. That, children at this stage are exempted from any types of labor, protected from corporal punishments, and are not responsible for any mistakes they could make. Based on this, physical and emotional abuse had no any impact on the nutritional status of children in the study communities.

However, the introduction of health extension program, the opening of health posts and their health professionals in recent years had improved the condition by creating awareness and by providing middle level medical services in each study kebeles. Thus, the nearby access for health posts and professionals had found to had positive effects on the improvement of children malnutrition problems.

4.4. Cultural Conception and Behavior on the Pregnant and Lactating Mothers

In these two physiological states of human beings, it is believed that their diet, physical activities, state of mind, cultural practices, social values and norms, and some other variables directly affect the physiology of reproduction and of the children both born and unborn. Therefore, pregnancy and lactation are not merely biological instances but also social and cultural phenomena which directly or indirectly imposed upon them. Accordingly, the discussion in this section of the analysis designed on such discourse

4.4.1. Cultural Conception and Behavior on Pregnancy

According to our key informants, *lekkaayyiritino*, (locally referred to pregnancy), is the state of mothers which is directly the gift of God who orders and determines when to conceive for fetus, what sex it should

be, when to be born, how it ought to be protected, even what behavior the will be child potentially has, on which any created human can change nothing. What so even appeared during the state of pregnancy on both physical and emotional conditions of a pregnant woman, it is the order of god that any individual can never alter it According to the FGD conducted with the malnourished pregnant women, even their actual state of malnourishment was believed to be the good will of the benevolent God, therefore, they argued that lose of weight (i.e. moderate or acute malnutrition) is nothing that needs not any action than praying to God whose power is his property. And if the loss of weight leads them to other illness (i.e. severe malnutrition), they look for go to medical treatments. Hence, from these discussions it seemed to point out two important conceptions that, on the one hand the cultural (religious) belief about the state of pregnancy, 'as the gift of God', led the group to conceive any ill instances on the body appearance of mothers, including lose of weight and malnutrition, as they were the 'the good will's of the God' who may had the plan to make delivery secured. On the other hand, even by the women themselves, lose of body weight on a pregnant women found to be considered as a normal body image of pregnancy, which paradoxically classified as moderate and/or acute malnutrition by biomedical measurements. Hence, the society's cultural and traditional conceptions on the state of pregnancy and perception on the body image of pregnant mothers had had direct negative impacts on their nutritional status that had indirect impacts on that of the unborn child.

Pregnancy is also a physiological condition that strictly demands changes in dietary intake, proper rest, exemption (at least deduction) of work-load, frequent visit to health centers and even change on sexual behavior than the time of the 'normal' body instances. However, the acquisition these demands are also culturally determined and are cross-cultural. According our informants both in FGDs and interviews, unless the household relatively in higher economic status, in most of the rural families of the study communities there had never had the habits of changing both qualitative and quantitative dietary change for pregnant women. To the contrary, there was a deep-rooted belief that 'a woman should reduce (minimize) her eating (quantity) during the last trimester (the last three months) of pregnancy. The indigenous rationale for this tradition, according to our key informants, was 'the will be child must not be fat that might cause death. Therefore, not only the absence of changes on dietary contents of the pregnant mother but also the traditional belief on the reduction of the amount of her food intake found to had critical direct impacts on the nutritional status of the pregnant women in the study group.

As our key informants stated that, 'in such rural community, unlike the urban counterpart, there is no way to employ a house 'servant' who shoulders the domestic duties of the households to minimize the workload of the pregnant women'. This is because of two reasons, on the one hand, it is impossible to get a woman or a girl who is native and willing to serve in the house which belongs for non-descent family/which is taboo within the community. On the other hand, the pregnant herself feels discomfort when another alien person to observe her children eating that might cause *ille* (evil eye) which culturally conceived as the root cause of the malnutrition. Accordingly, the research found that the persistent and day long gender constructed domestic workloads of the pregnant in the communities studied contributed for their malnourishments (under nutrition). Thus, this condition found to contribute negative psychological impacts on the state of mind of the pregnant women.

Thanks for the access created by the government and its health extension policy, pregnant mothers had regular attendance and follow up by medium health professionals in each study kebeles. According the health professionals in the FGD, even if a pregnant woman didn't came to the health post on the date of her check up, the next day the nurse will go to her house and perform the task. As the result, the condition of pregnant' health care attendance and follow up had no any negative impact on their nutritional status, even it had been contributing for its improvement.

4.4.2. Cultural Conception and Behavior on Lactating Mothers

Child birth in the study community, like most of Ethiopian rural communities, is more than just physiological event. It is culturally and socially patterned rite of passage both for the mother and the new comer. Because, it is state of transition from womanhood to the status of motherhood and it is addition of one new member for the family of the clan as well. The birth ritual that takes place in one household, accordingly, is the concern of the close relative and even the clan members. With certain economic and social status variation among households of the study area, according to the key informants, just when a women had given birth without any problem both matrilineal and patrilineal relatives would be gathered to the house and participate in celebration conducted with the processes of singing, eating special foods (usually made of butter, cheese, meat and *enset* which is locally named as *borrssemme*) where every attending women putting loaf of fresh un boiled butter on the hair of the delivering mother which symbolizes the request of the group to let breast feed (*qansaanimo)* her new born child. This was the beginning of lactation in the study community, where the mother considered her as the queen. From this time onwards a newly delivered mother will stay from 30 to 60 days at her bed, depending on the level of the household's livelihood, with special dietary provision and care as well as without having any task in the household activities. Because, it is socially taboo for a husband if his wife appears unprotected and lose her weight during her birth leave. Therefore, lactating mothers were found cared and protected from malnourishment during the time from birth up to 30/60 days because of the special nutrient rich diets and cares the group given for them. And this showed that cultural belief and practice could alter the status of malnutrition both positively and negatively.

According to the information gathered during our observation and also as it was confirmed by our informants, just after the first day of the end of her birth leave, the lactating mother begun to shoulder the domestic and other loads that she had been responsible before besides to the tasks of breast feeding the new born child. Surprisingly, not only the commencement of the intensive work load, to the contrary the care conducted by the group

and the special dietary provision, which was during the birth leave, had also been quitted at all. Then, it is a point where malnourishment started that while a lactating mother needed to have additional rest, nutrient reach foods, and exemption from hard work, to the contrary she had been deprived of all such things which her actual physiological conditions demanding critically. Hence, the gender constructed intensive work load, restless life and absence of care had found had direct negative contribution on the nutritional status of lactating women in the study community.

In general, the culturally patterned role and status of women and socially constructed gender hierarchy, in the study society, as well as the extended and unplanned family structures found directly contributed for the recurrence, frequency and prevalence of acute, moderate and severe malnutrition (under nutrition) among children (<5), lactating and pregnant mothers.

5. Conclusion

It was vivid reality that scarcity or availability of livelihoods alone can not necessarily determine the rate and prevalence of malnutrition, but the social and cultural contexts of the households also have triggering impacts. From this we can see that the recurring and persistent nature of malnutrition couldn't be explained in terms of access for resources alone that even the access is available there can be the recurring malnourishment due to misuse of the available access because of the cultural and social beliefs and practice.

The frequency of getting such nutrient rich variety for the children (under 5), pregnant or lactating mothers was rare and even challenging which might contribute for their under nutrition cases. Because, these prestige foods, which usually protein and difficult to obtain or prepare, are linked socially and culturally with dominant patriarchal group in the study communities. The research investigated all these main aspects to explore whether they are influenced the nutritional status in the study groups.

It was logical to conclude that the traditional frequency of breast feeding practice in the study communities directly contributed for the under nutrition of the children under five years of age because it below the normal description biomedicine. The belief on success in breast feeding on God directly affects the possibility of getting enough breast milk through improvement of diet and physical conditions of the mother which the belief indirectly had negative consequence on the nutrition status of the child and the mother.

from these discussions it seemed to point out two important conceptions that, on the one hand the cultural (religious) belief about the state of pregnancy, 'as the gift of God', led the group to conceive any ill instances on the body appearance of mothers, including lose of weight and malnutrition, as they were the 'the good will's of the God' who may had the plan to make delivery secured. On the other hand, even by the women themselves, lose of body weight on a pregnant women found to be considered as a normal body image of pregnancy, which paradoxically classified as moderate and/or acute malnutrition by biomedical measurements. The society's cultural and traditional conceptions on the state of pregnancy and perception on the body image of pregnant mothers had had direct negative impacts on their nutritional status that had indirect impacts on that of the unborn child. The condition of pregnant' health care attendance and follow up had no any negative impact on their nutritional status, even it had been contributing for its improvement.

Lactating mothers were found cared and protected from malnourishment during the time from birth up to 30/60 days because of the special nutrient rich diets and cares the group given for them. And this showed that cultural belief and practice could alter the status of malnutrition both positively and negatively. The gender constructed intensive work load, restless life and absence of care had found had direct negative contribution on the nutritional status of lactating women in the study community.

In general, the culturally patterned role and status of women and socially constructed gender hierarchy, in the study society, as well as the extended and unplanned family structures found directly contributed for the recurrence, frequency and prevalence of acute, moderate and severe malnutrition (under nutrition) among children (<5), lactating and pregnant mothers.

Acronomys

UN-WFP-united nation, world food program
CSA- Central statistical authority
UN: UNICEF-united nation,
EOS- Enhanced Outreach strategy
SNNPRS-south, nation, nationality, peoples and regional states
WFP-world food program
UNDP- united nation development program
ENI-Ethiopian Nutritional Institution
FGD-focus group discussion
FAO- food and agriculture organization
MUAC-Mid- Upper Arm Circumference
TSF- targeted supplementary food

Glossary

khat -an ever green shrub whose leaves are chewed as stimulant
sidamoo afe-language that belongs to the eastern highland Cushitic sub-group of the Ethio-Cushitic family of languages
Gosa-tribe
Bisallo-clans
Aydde- division that consist all descendants of one ancestor for about the three or five generations and which consists an olla
Olla-village
Halale-Social rule
Weinadega-mid- land
Kolla-dry-lowland
Kebeles-selected peasant associations
Enset -false banana
tima -local bread made from maize flour
shna -cooked cabbage soup
godere -local potato
Shoomaancho-breakfast
Barrihurbaate-dinner

Qonsaancho -adequate breast feeding
Lekkaayyiritino-locally referred to pregnancy
ille -evil eye
Borrssemme-locally name for enset, Qansaanimo-breast feed

Acknowledgement

We would like to express our deepest gratitude and heartfelt thanks for Dilla University, Research and Dissemination Office (RDO) helping for the academic staffs to do a research and to become a real researchers and academicians. Thus, the support of RDO in finance, material and seriously follow up was useful and constructive to finish our research.

Our warmest and honorable thanks also go to all our informants and other responsible bodies of the Borecha woreda,Sidama Zone without whose contributions our work would have not been possible. Last but not least, our special appreciation is due to School of Social Sciences for its encouragement to participate in other researches of the University.

References

[1] Africa Region Working paper series: child MW in Ethiopia 2001 No 20
[2] Bahir Zewde. (2006). Systems of Local Governance among the Gurage: The Yajoka Qicha and the Gordanna Sera.
[3] Cecil.G.Helman, 2000. Culture, Health and illness Bulter worth printing press.
[4] Central Statistics Agency of Ethiopia, 2005.
[5] Dawson. C.2007. Practical Guide to Research Methods 3rd Ed. How to use Book London. Uk
[6] Dettwyler.K.A 1992 Bio-cultural approach on nutritional anthropology. Hougnton Muttin.
[7] DPPA/Humanitarian partners, (2007/8), Humanitarian Appeal for Ethiopia: 2008/2007.
[8] ENCU/UNCIEF/WFP, (2008), EOS Data quality Check Guidance note (unpublished).
[9] ENI, (1990), Ethiopian Nutritional Institution Report on nutrition survey.
[10] Gugsu Yimer – MN among children in south Ethiopia, Eth.J. Health Dec 2000.
[11] Harris M/ Orana Johnson- 2007 Cultural Anthropology, 7th Ed. Pearson Education. Inc. USA.
[12] Harrison. C 1993: Breast feeding and weaning in the poor urban neighboring in Cairo, Egypt Social Science Med.
[13] Homans .H.1982. Pregranancy and Birth as Rites of passage for two groups of women in Britain. Academic press.
[14] International Statistical Institute (ISI) 1984, World Fertility Survey.
[15] International statics Institute (ISI) 2010: World Fertility Survey.
[16] Jelitte D.B 1967: Parallel food classification in the developing and Industrial Societies AM. Jclin Nuter.
[17] Keesing R.M.1987 Cultural Anthropology. Holt, Rinehart and Winston.
[18] Keessing, R.M-1981- Cultural Anthropology, Holt, RINE Hart-New York
[19] Livi-Strauss, (1961), The Raw and the Cooked-Oxford press
[20] Masefield, A. (2001), Chronic Food Insecurity in Ethiopia: Looking through Livelihood Lenses.
[21] M.L. Bender, 1976 – Languages in Ethiopia. Oxford University Press, UK.
[22] Maxwell, S. (1992), Household Food Security concepts, indicators and measurement
[23] Nebiyu Melaku. 2007- Agro-ecological comparison nutritional status of children AAU-Theses.
[24] Pottier, J. (2005), Anthropology of Food: The social Dynamics of Food security, Polity press.
[25] Sidama Claster Health Profile, ESHE, SNNPRS, Ethiopia 2005.
[26] SNNPRS, 2003.Household health survey, Hawassa.
[27] Straut Gillespie: assessing the food and nutrition situation in the rural Guatemala 2001
[28] Tollosa, D. 2002, Household seasonal food Insecurity in Oromia Zone, Ethiopia, social science research report No 26
[29] Tollosa, D. (2005), rural livelihood, poverty and food insecurity in Ethiopia-NTNU-Trondheim
[30] UN, (1975), Report of world food conference-Rome 5-16, NOV.1974, Network
[31] WFP, Emergency Field Operation Pocketbook, 2007 (unpublished).
[32] Zewditu Getahun2001, Review of status of MN and trends in Ethiopia. Ethio.J, Health development.

Appendix I: Interview schedule

This interview schedule is designed to be used as a guiding tool for the individual interviews conducted with elderly knowledgeable persons and other relevant individuals in the study communities who were considered as key informants during the entire period of the fieldworks. The schedule contained certain basic points, the researchers believed, which were relevant to investigate the research objectives and to address the proposed questions. All the basic points were those, directly or indirectly, have strong interconnections with the basic variables of the study i.e. Culture and Malnutrition (under nutrition) of children and mothers.

Part One: - Context, this includes

1:1 Occupation

- Whether man and women in the households follow similar or different occupation?
- Whether certain occupations are reserved for a particular group (individual) member of the household?
- Whether certain occupations have the higher prestige or rewards in the households?

1:2 Religions

- Whether there are food taboos in the community? If any, what are these taboos?
- What are religious beliefs and cures about the causes and remedies of malnourished child, pregnant and lactating women?
- What are the religious norms and values towards the state of being pregnant and lactating women?

1:3 Traditional treatments for the therapy of malnutrition (under nutrition) children and mothers.

- Use of herbal or/and spiritual remedies
- Special diet provision or preventing from certain types of foods.
- Body manipulations
- Praying

- Holy water
- Shamans

1:4 Cultural conception and causation of malnutrition (under nutrition) children and lactating and pregnant women

- It may be the result of curse from god or some super natural power
- It may be the result and symptom of other diseases and infections
- It is the result of deficiency of care and nutrients
- It is normal to be seen when child is under five years of age and when a woman is either pregnant or lactating

1:5 Traditions of personal and household hygiene and sanitation

- Whether personal and environment hygiene are encouraged or not
- The mode of disposal of human and animal wastes and their area of disposal

Part two: - social organization and cultural practices this includes

2:1 Economic empowerment in the households

- Whether wealth and its decision making power are evenly distributed throughout the members of the family?
- Whether the wealth earning, accumulation and management are duty of both wives and husbands in the household or not?

2:2 Family structures and marriage patterns within the community

- Whether the family in the communities is extended or nuclear?
- Whether the polygamy, monogamy or polyandry encouraged within the communities?
- Whether levirate or sororate remarriage system practiced as normal in the groups?
- Whether marriage in the communities endogamous or exogamous?
- Whether early marriage is normal in the communities?

2:2 culturally constructed gender role, status and power in the households and within the community

- The division of labor between the two sexes in the households specially on who works out and who remains at home, who prepares food and cares children and the like
- The social rights, obligations and expectations associated with the two sexes
- Cultural norms and beliefs about the behavior appropriate to the two sexes such as alcohol consumption, smoking and competitive behaviors being regarded as normal to men but not for women.
- The right and the degree of power to consultation and take medical treatment when there is illness
- Cultural norms on decision making on economic resources, social affairs and medical practices

2:3 Population Policies

- The cultural attitudes and beliefs about family planning
- The culturally normal size of a family
- The knowledge and attitude of the group towards use of modern contraceptives and accesses to get them

Part Three: - The indigenous beliefs, knowledge and behavior about the states of being pregnant, breast feeding women and child under (five years of age)

3:1 Cultural perception of pregnancy and breast feeding

- Whether they are result of biological or spiritual instances?
- Whether they are situations which need special care and protection of the body such as more rest, additional food items and exemption from hard works or they are normal physical and mental conditions which need nothing special.
- Whether these situations need frequent visits to health stations?
- Cultural values and beliefs in relation to pregnancy and lactation

3:2 culturally defined normal body image of a child, pregnant and lactating women: -

- What are the normal instances of size, height and weight which the group defined as normal for these kinds of mothers and children (under five age) under a given period
- At what level of body image that the society conceives a mother or a child is under nourished
- What measures are traditionally available in the group as an options of cure for malnourished mothers or children

3:3 Child rearing practices

- Whether initiation rituals carried out after birth such as circumcision at what age level and by whom?
- Whether additional and special food stuffs and types are provided for children less than five years?
- The degree of physical and emotional abuse one's own child regarded as normal for the society?
- Whether there is labor duty expected to be performed from a child less than five years of age?
- Whether the relief nutrient rich and blended foods delivered to malnourished child properly addressed in the households targeted as beneficiary?

REMARKS: - All these and other emerging points, during each session of discussions, were discussed in the course of 24 interview sessions on aggregate with our informants in both study sites proportionally.

Appendix II: FGD Interview Schedule

This schedule also used as guiding tool for the discussions held in groups of individuals patterned based on their common characteristics and occupations conceived relevant to the main objective of the study. Most of the topics discussed in each group are presented respectively in the table below.

Focus Groups	**No of participants**	**Main issues discussed**
Pregnant women (malnourished)	7	The cultural value, definition and measurement of under nutrition Emic understanding of the causes and remedies of malnutrition during pregnancy The availability of special care during pregnancy in food and rest time The role and power of women in the family economic and social affairs The regular attendance of formal health care services during pregnancy Food taboo and preference during pregnancy The status of mothers and children in food distribution and priority in the family
Lactating women (malnourished)	7	The cultural value, definition and measurement of under nutrition Emic conception of the causes and remedies of under nutrition during breast feeding Awareness and accesses for special food delivery and more rest for lactating women Birth delivery and child care The frequency of lactation per a day and for how long it will continued Food taboo and preference during breast feeding The status of mothers and children in food distribution and priority in the family
Malnourished child's mothers	7	The cultural value, meaning and measurement of under nutrition The level and identification of the body image of malnourished child The traditional treatment when the child is malnourished The proper use of the relief food and blended nutrients delivered for the malnourished child from health centers without sharing to the others The possibility and accesses to formal health care centers Child health and care practices
Male household heads with the problem	7	The gender role and status of the two sexes in the household The role of husband in the household when mothers are suffering from under nutrition who are pregnant or lactating Special care for lactating or pregnant women and malnourished child Awareness about the special condition of the body of mothers during pregnancy and breast feeding The special rights of house hold head husbands in terms of resources and foods distribution The condition of physical and emotional tension on the mothers and children
Health post professionals	5	The linkage between health and under nutrition The people level of awareness regarding preventive and curative cares of under nutrition Constraints and challenges to deliver sustainable cure of under nutrition Scientifically prescribed special cares for pregnant and lactating mothers also for malnourished children The impacts of malnourishment during pregnancy on the new born child and lactating women The level and prevalence of the problem and its relapsing rate
Relief aid workers and religious leaders	5	The implementation the relief aid deliveries for the targeted malnourished person The action available to cope with the problem The possibility of monitoring and evaluating the periodic output of the relief aid package delivered to the family

Appendix III Key Informants

Key informants	Yirba-Duuwancho Kebele	Belila-Medolomukeanqa Kebele	Total
Male	1	1	2
Female	1	1	2
Total			4