

THE IMPACT OF POVERTY ON CHILD MALNUTRITION AND ITS MANIFESTATIONS IN ETHIOPIA

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Abstract:

This paper presents the results of qualitative research aiming to study the influence of poverty on defined examples of malnutrition in children from families in southern Ethiopia. The research methods were ethnographic interview and participant observation of children with kwashiorkor syndrome and marasmus treated at the Hospital of Mother Teresa managed by the Missionaries of Charity in Kibre Mengist, a town in southern Ethiopia. The target group were ten children from nine families and family members who accompanied the child to the clinic. The research aims to answer the question of what the Ethiopian family with child with malnutrition looks like and what are the possible causes of malnutrition were sought. The research aimed to articulate the impact of the social environment on the child's condition and the possibility of effective social work interventions, in Ethiopia and more widely.

Key Words: Poverty. Frequency of families, Hierarchical dining, Monotony of eating

Poverty has always existed and still is everywhere. Nobody knows how to define it really, but we all know what it is. Extreme poverty goes hand in hand with malnutrition.

In the years 2011 - 2012, we worked on an empirical research thesis. In formulating the theoretical basis of our research, we used different concepts of poverty, through experiences of it (Altimir-Bragg in Social Watch), through its causes (Payne, Kusá and Džambazovič), in terms of maintaining human rights (Žilová, United Nations Population Fund in: Social Watch 2010) and in terms of the stratification of society (Mareš, Berger, Keller, Evans-Pritchard, Jandourek, Sopóci, Búzik, Marx, Weber, Durkheim, Parsons, Davis, Moor, Dahrendorf and others). The object of the research was poverty and malnutrition of the rural population of Ethiopia.

Under-nutrition or malnutrition is a general term for the medical condition caused by an inappropriate or insufficient diet. "Malnutrition is the lack of sufficient nutrients sustaining healthy body functions and associates with extreme poverty in economically developing countries. It is a common cause of reduction of intelligence in parts of the world affected by famine" (Benca, 2006, p.104). Some authors (Benca) divide malnutrition into protein-energetic and micronutrition kind, some (e.g., King M, King F, Martodipoero) divide it into a mild form and an acute form (Benca, Bielová, Werner, King et al.).

For the purposes of our research we will describe here only the two most serious types of child malnutrition: marasmus and kwashiorkor.

Kwashiorkor or hypovitaminosis is caused due to the lack of protein and variety of food. The child, seemingly plump, consumes corn dishes monotonously, causing leakage of fluid through blood vessels inside the body. It causes swelling, particularly of the legs, skin and hair changes, slow growth, mental and metabolic disorders. Marasmus or even cachexia is caused by a chronic and long-term lack of energy-valued food. There is a loss of adipose tissue and muscle, slows the growth and development, the child has a geriatric appearance, big belly and is abnormally skinny.

One co-author of this paper worked as a masters student (and currently is working again) volunteering in the small town of Kibre Mengist in area called Adola, about 450 km from the capital, Addis Ababa, in southern Ethiopia, in small clinics organised by Mother Teresa nuns in an anti-malnutrition program. Our original intention was to examine the manifestations of poverty, particularly malnutrition, in Ethiopia and compare it with the situation in Slovakia. We had the idea

that if we understand the symptomatology of poverty in particular malnutrition the poorest country in the world, in Ethiopia, so we can more easily capture signs of malnutrition and poverty in Slovakia. From the outset, however, there were many complications making this time-limited research (June - September 2011) extremely complicated and therefore we stepped back from making comparisons and built up qualitative research on the Ethiopian survey sample. A background cause of poverty and child malnutrition in Ethiopia is the lack of water or contaminated water, causing serious health problems. Adverse weather conditions are also relevant, leading to crop failure and food shortages. Illiteracy, habits, different spreading diseases (tuberculosis IIDS, parasites, etc.) contribute to this misery. In traditional Ethiopian family mothers have eight or more children. In such families, the father has a dominant position, and this is reflected in daily life and, therefore, in diet. Chronic food shortages mean that it is very likely that the child gets into a state of malnutrition. First, the father has to eat and then they eat from the oldest to the youngest child. This is true not only in terms of quantity of food, but also the quality. So not much food remains for the youngest child and, if there is something left, it is only the very bad and poor quality part of the food. In addition to these factors, malnutrition is also influenced by low birth weight and by physical proportions of the mother. Babies are born with low birth weight, often with developmental defects such as short stature, reduced intelligence, immune disorders, and frequent infections. Mothers often suffer from iodine deficiency, which causes mental handicap to their children, or iron deficiency occurs, which causes severe anaemia. Vitamin A deficiency causes blindness and affects the immune system.

The aim of the research was to analyse the socio-economic conditions in nine rural Ethiopian families, and to identify the impact of family poverty on the malnutrition of their children.

The target group consisted of family members (five mothers, one father, one sister, one brother, one grandmother) of a malnourished child. The research involved in a total of nine families (ten children, seven girls and three boys), all coming from the poorest regions of southern Ethiopia. Children were classified on the basis of medical diagnosis in an anti-malnutrition program. All children came to the hospital in a critical condition, five out of the ten children suffered from marasmus and five had the kwashiorkor type of malnutrition. Interestingly, three of the families studied were not considered poor in Ethiopia. The age of children involved was from one to eight years. Apart from one breadwinner, who worked in gold mining for living, all the farmers were illiterate.

As a method of investigation, we chose ethnographic interviews and participant observation, made in the field. The interview was semi-structured, translated into the local language Oromo or Amhara. This interview was conducted as part of the work at the clinic during medical interventions in the anti-malnutrition program. Questions were formulated into 16 areas: basic case-historic data on child and family, the socio-economic situation of the family, traditions, habits and behaviour at the table, on the quality and quantity of eating, on the crops or harvest, on education and occupation of family members, and on behaviours that could cause the child malnutrition. The process of interviewing became very difficult. The question had to be translated from Slovak to an English interpreter, and he translated it from English into their native language Oromo and from Oromo into the Amhara language which respondents used. Another complication was conducting the interview itself. He had dealt with it only as part of the treatment of children, so there was not much opportunity for detailed writing or recording of the answers.

Notes from the responses were made very quickly, while the interpreter translated another question. The observation also was not the easy in the circumstances. We had no equipment and other than observation and we had to carry out our job in providing assistance to children in the program. The child was at the clinic about six to eight hours a day for diagnosis and treatment. We watched not only the child's behaviour, but also the person who accompanied them to the clinic. We observed their habits and customs of feeding and caring for malnourished child, and we assume that this would partly reflect their behaviour towards the child in the domestic environment. Another difficulty was the impossibility to revise our knowledge, respectively to acquire new information because the family with whom we have worked in the clinic, would not return back again and we did not have any contact with them anymore.

To achieve the goal we set two research questions: 1) What is the family, of which the malnourished child is a member like? and 2) What are the specific causes of malnutrition in particular children?

Through ethnographic interviews and participatory observation, we processed recorded information on individual families into nine family profiles.

From the results of the qualitative analysis, we found that the family in which the malnourished child lives is almost always a multiplex family, i.e. with more than five children. The family probably does not have enough food for everyone, so not every member of the family gets the same kind of care and nourishment. In our study, there were nine families and in five cases there were from ten to 20 children in the family. On the other hand, there was one family with only one child in the program and the other families had three children. In that culture it does not matter whether the father of a family has several wives, only children count, because he is supposed to be able to take care of them.

We expected that the main cause of malnutrition would be Ethiopian family dining traditions. That involves the father's pre-emptive right to choose and eat food first, which determines what portion remains to children. The food then passes from the oldest to the youngest. The hierarchical approach to eating had been thought to be an important cause of malnutrition in our study sample of children. Despite this expectation, we found that only two families professed allegiance to this way of dining. The remaining seven families ate meals together and at the same time, with equal portions of food. In one family, even, the children ate first and then food passed to the adults. It was found that a much more serious problem is the repetitive consumption of food (corn and bread) or severe liver disease, and chronic lack of food that causes shrivelling of the stomach and lack of appetite and nearly as strongly the drinking of contaminated water, causing diarrhoea and vomiting.

On the basis of the socio-cultural knowledge we acquired, we assume that the critical malnutrition is the result of family poverty, lack of crops and a monotonous diet. According to our criteria, we considered all the family very poor, but only three of them subjectively experienced poverty. As most respondents were farm families, we asked them what they grow or produce, what they buy and what animals they keep. Mostly they grow, sometimes buy corn, cabbage, some vegetables or oranges and lemons and teff in any form. They also own one cow for milk and meat, hens for eggs and meat, and besides that, they have nothing. One family owned a donkey and goats, but they did not use milk from them. They do not eat eggs, but sell them so they can buy oil and sugar. If they are able to obtain butter and milk, only the father consumes them. Others eat only corn and cabbage prepared in different ways. They usually eat twice a day. Crop production is marked by very poor knowledge of farming. Each year, they sow the same kind of crop which gradually degenerates and is not renewed; they are unaware of irrigation systems and so they are dependent on nature.

From our analysis of family profiles, we were unable say that the cultural context of families does not allow us to identify the characteristics of Ethiopian families with the malnourished children. In the Ethiopian context, children from multiplex families may develop acute malnutrition much more quickly than children from families with fewer children. However, having a large number of children in the family may not clearly indicate that children will be malnourished or vice versa, that a child from families with fewer children do not become malnourished. The traditional hierarchical system of diet is also not clearly identified in the research as the cause of malnutrition of young children. We would have to examine extensively, for example, the family constellation of a specific malnourished child, the family atmosphere, the role of the family in the community and related matters to identify the full range of causes. The lessons learned from this research allow us to claim is the cause of malnutrition in children observed is the lack of food, lack of an energy-dense and varied diet, the generally low level of knowledge of parents not only about health and family, also about the cultivation of crops and effective handling of the harvest.

In conclusion, we would like to express the regret that we did not do a comparative study of signs of malnutrition caused by poverty in Ethiopia and Slovakia. We found it difficult to identify a research sample for our work in Slovakia. We assume, however, that it is certainly possible in some notorious "social ghettos" of Slovakia to find similar children, and not just children from Roma settlement environments. Perhaps, there are even children paediatricians see in their clinics and do not

identify that an apparently neglected or perhaps abused child is really malnourished. Maybe they do not suffer from disease of kwashiorkor or marasmus yet, but there are parallels with the Ethiopian situation. Malnutrition is a manifestation of extreme poverty. The consequences of malnutrition may be resolved by medical intervention, but they can be prevented only by excellent social work interventions.

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