

A COMPREHENSIVE APPROACH TO COMMUNITY WELFARE

GROWTH MONITORING AND THE ROLE OF WOMEN IN JAMKHED*

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During the past decade numerous articles have described the success of the Comprehensive Rural Health Care Project at Jamkhed, now embracing a population of almost 200,000 people in 175 villages in one of the poorest, eroded and drought-prone areas of Maharashtra State. Although at the outset the intentions in developing a rural health project were aimed at alleviating the high mortality and the degrading health conditions of this poor and deprived population, we rapidly discovered the power of these communities themselves to recognise and take effective action to deal not only with ill health but also with an entire range of comprehensive development. This capability has made the area, in spite of its chronic drought, high illiteracy and scanty infrastructure, a community of good health and vibrant self-reliance.

Our introduction into the community was facilitated by the establishment of a small rural hospital and our offer of curative health services to a needy population. From this base we soon learnt the three critical elements of community development:

1. The community can and will actively participate only if it identifies and addresses its own needs in the order of priority that they see fit.
2. It is the act of helping themselves, of carrying out development activities by planning, implementing and discussing the results, which makes a community program resilient. This does not mean being told what to do, or acting as an assistant to an outside professional person, but rather a full delegation of responsibility and authority to community members.
3. There are no simple solutions to the problems of life in a rural and impoverished community in India. Thus, any approach must be multi-sectoral and deal, to some extent, with the entire range of problems faced by people living in these communities where health and nutrition considerations often provide an entry point. They cannot by themselves bring about community development, nor indeed can health and nutrition intervention alone assure good health and nutrition.

These three principles embody the underlying philosophy and strength of the Comprehensive Rural Health Project in Jamkhed and account for the striking results achieved over the past 15 years.

Objective data show that crude mortality has fallen from 15 to 8 per 1000, and infant mortality reduced from over 120/1000 live births to between 18 and 23, perhaps the lowest in rural India today. Crude birth rate has similarly fallen from 40 to 22, with modern contraceptives being used by 55% of the couples and by 75% of all couples with more than two children. Significant malnutrition has declined, from over 30% of all children to less than 6%, and 98% of children are immunised by the age of two years.

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Introduction of growth monitoring

While these statistics provide an objective view of the project's success, it is only by visiting a village in the Jamkhed area that one can gain a full appreciation for the dynamic process of development which has occurred there. No activity is more typical or critical to the success of the program than the monthly growth monitoring activities conducted in the villages under the guidance of volunteer village health workers and their friends and neighbours. An understanding of the evolution of growth monitoring and promotion in Jamkhed provides an insight not only into nutrition interventions but, more importantly, into the role of women, into comprehensive primary health care, improved farming and community-based problem solving which has characterised the success of this movement.

In the early years of our community activities, we conducted a periodic mobile clinic in each village throughout the area. During this time, we provided the usual range of preventive and promotive health services including antenatal care, immunisation, child weighing, as well as curative care for the illnesses we encountered. We, of course, enlisted the aid of the villagers themselves in conducting the weighing and assessment of nutritional status of the children and found that even the illiterate soon became accustomed to interpreting the "picture" that a child's growth line made on his own individual card. As we trained village volunteers to handle an increasingly large part of our work, both curative and preventive, the regular monitoring of growth of village children became a village activity in which illiterate workers were helped to mark cards by their husbands or own school going offspring.

In 1972, soon after the program began, the area was struck with a severe drought with prolonged food shortage and extensive crop failure. This was nowhere more visible than in the arrested growth of the entire young child community, and it was only through appropriate use of donated food stocks that many of these young lives were saved. The visual impact of donated food on the growth of these children was seen by the community, and subsequently used by them as a means of measuring their own food production and adequacy of food availability in the community. Both the farmer's clubs and *mahila mandals* (village women's clubs) began to look upon the individual weight charts kept in the village by the volunteer mother conducting the monthly weighing session as a measure of village food stocks. Noting that more children did not gain weight during July and August in the pre-harvest season, a number of communities established special feeding programs from village food stocks in the form of community kitchens for the poorest children during the lean season. Club members contributed money or grain and measured the success of their activity in the growth of village children as a whole.

Growth is more than health alone

Growth monitoring by the villagers was able to show how a well-meaning development programme can have a detrimental effect on the health of children, an effect that could have gone undetected. In one village about 20 women received subsidised loans for cows. Several months thereafter the *mahila mandal* noticed that the children of those women who had received the cows were not gaining the weight. The problem was discussed and analysed, and it was found that these women were not only selling all the milk from the cows instead of giving it to their children. but they were also having problems in buying fodder for their cows and therefore were taking away the precious money meant for their children's food, using it to keep cows alive. We then contacted other villagers and were able to demonstrate the same problem. A decision was taken by the *mahila mandal*, and the cows were sold off, the loans repaid, and instead the women were given loans to buy goats. Goats were found to forage

more successfully and the lack of market for goat milk ensured that this was given to their children, resulting in improved growth in program children associated with this village-based action.

The growth monitoring strategy has also enabled the community to understand the relationship between growth and development of the child and the array of minor and major illnesses that are commonly found in the village. Long before the recent availability of measles vaccine, village health volunteers complained to us that during the measles season a major fall in weight was seen in many children. The heavy demand to prevent measles infection enabled us to obtain donated vaccine and protect our villages based on community demand for immunisation. The common problem of motivating people to accept immunisation was not even an issue. Villagers have also drawn to our attention the association between frequent diarrheal diseases and the flattening growth lines on the charts of their children. This has led to discussions of how to reduce the incidence of diarrhoea and improvement in sanitation and environment, even in the poorest communities of these villages.

On an individual basis, growth monitoring has been the key tool leading to an early diagnosis of more than 10 children with tuberculosis, who had no apparent reason for their faltering growth and lack of weight gain and who on referral to our hospital were carefully investigated in view of the clear record of non-weight gain. As a result they received an early diagnosis of primary tuberculosis and were appropriately treated.

Result over ten years

An analysis of the achieved weight of children under three years of age compared 1000 children weighed during 1975 with a group of 3000 similar aged children 10 years later. Not only is the mean weight now well above accepted international standards, some 1.5 to 2 kilograms higher than it was 10 years ago, but importantly the spread of weights reflecting the wide range of nutritional status has reduced substantially, leaving less than 6% of under three-year-old children now falling into this moderate and severe malnourished groups, compared with 30% in 1975. The weight record and nutritional status of young children in Jamkhed is itself an objective testimony of the effects of development in a region that remains even today poor and environmentally degraded.

Recognising this improvement, over the past several years, I have suggested to women's groups on a number of occasions that perhaps they wish to stop the regular weighing of children in their communities. Thinking that this was a burden on their time and energy, it seemed that their accomplishment in terms of lowered mortality and improved nutritional status may have obviated the need for this recurring promotive health and nutrition activity. Consistently, I have been met with strong objections on the part of volunteers, women's groups and the farmer's clubs who together say, "It helps us to explain what is going on." "It helps us to see far earlier than any other way what is happening in our community." "We can tell before a child is sick and see the future of our community in the weight charts of our own children." Far from being a burden, growth monitoring is viewed in these villages as the monitoring of the growth of the entire community and of the adequacy of their attention to the future generation.

Problems encountered

But the introduction of growth monitoring as a strategy for community development has not always been easy. Interestingly, in stark contrast to what is often written, we found illiterate women to be the ones most understanding and capable of appreciating the interpretation of the line on the growth chart. While trained health workers, particularly those trained formally, such as nurses and ANMs, gave maximal attention to nutritional status and were greatly concerned about the precision of weighing and plotting, illiterate women saw the line on the card as a picture of each child. While most village health workers in Jamkhed are illiterate, all can recognise and describe each individual child from a pile of weight charts representing 30 or 40 children's weight records in their own village. Far from a detriment, illiteracy seems to be a positive attribute in appreciating the importance of growth monitoring.

Our most difficult task has been stimulating the health staff, particularly the ANM and multipurpose male worker, to understand the importance of growth monitoring as a tool in the development process. They tend to look at the weighing and plotting as an exercise complete in itself and fail to understand the full meaning of "how it can be used by the community to stimulate action." We have found that social workers and non-medical development workers are better able to appreciate and stimulate growth monitoring and promotion activities that result in a community-based sustained action program. These workers help the community to solve some of the problems that arise and provide specific suggestions to improve the weight of groups of children showing faltering. Improved water supplies, raising of small animals, and home income producing projects, as well as emergency feeding on a targeted basis, have made growth monitoring an action program.

Another problem encountered in the beginning was the community's opposition to taking the weights of children. Superstitions and taboos regarding weighing were very prevalent; particularly birth weights were difficult to obtain. As weighing was carried out by village women themselves, they soon became accustomed to the procedure, and traditional taboos faded into the past.

In conclusion, our 15-year experience with growth monitoring has shown us that when placed clearly in the hands of villagers, growth monitoring becomes the tool of development and an integral part of the community participatory process. We attribute the success of this program predominantly to:

1. Emphasis on the organisation of community participation and to the attitude that the community is capable of planning, implementing and evaluating its own developing activity.
2. The complete delegation of responsibility and authority with support and encouragement from professional staff.
3. Growth monitoring does not exist in a vacuum but is part of an overall strategy, not only for primary health care but also for a comprehensive rural development program.
4. The pride of the community in their own future generation is reflected on a monthly basis in the regular growth of all the young children.

The community sees this as a measurable outcome of their own efforts in multi-sectoral development and find it a more understandable and measurable result than the parameters more often seen and viewed by Western-trained health workers -- e.g. a fall of infant mortality to levels seen in developed countries, a fall in malnutrition rates equivalent to communities with far higher incomes, and a spontaneous reduction in desired family size associated with an improved outlook for survival and quality of a healthy and hopeful life for the children of the Jamkhed area.