Mee Lian Wong & Paul C. Y. Chen

Self-reliance in health among village women

A women's committee in a remote part of Sarawak, Malaysia, using community resources and benefiting from some external catalytic support, has successfully planned and implemented a health development programme.

Remote, sparsely populated and economically depressed communities are often underserved because national resources are limited and inaccessible. Centralized planning frequently fails these communities and attempts at decentralization have met with limited success as they have usually been confined to functions and have not embraced decision-making *(1)*. One solution consists in involving village women in health development. We report here a project in which village women were mobilized to plan, implement and evaluate a self-help kindergarten and children's feeding programme.

The work was conducted among members of the Berawan tribe in the village of Long Jegan, Baram District, Sarawak. This village, accessible only by river, has a population of 450 housed in a single communal longhouse of 61 *bilik* (apartments) (see photograph). The Berawans tribe are shifting cultivators of hill paddy, and also engage in fishing, hunting and fruit-gathering. Their social relationships are characterized by harmony, cooperation and reciprocity. Women are ranked below men and have limited home-making roles. Although they predominate over men in agricultural activities they traditionally have no decision-making power in the domestic economy or village development activities. Malnutrition, diarrhoea, worm infestations and infectious diseases were prevalent among children, while adults commonly had tuberculosis.

Dr Wong is Teaching Fellow in the Department of Community, Occupational and Family Medicine, National University Hospital, Lower Kent Ridge Road, Singapore 0511, Singapore. Dr Chen is Regional Adviser, Human Resources for Health, WHO Regional Office for South-East Asia, World Health House, Indraprastha Estate, Ring Road, New Delhi-110 002, India.

Community preparation

A year prior to this project, contact had been established with the community through the training of village health promoters *(2, 3)*. Nevertheless, the participatory approach to planning was a relatively new experience for Berawan women, who therefore had to be prepared and organized.

A meeting was held with the village headman and elders to explain the purpose of the project and to request permission to train women in data collection and health

care. Eighteen mothers, mostly aged 20–35, who had had at least four years of schooling, were selected.

Training was conducted in the village headman's *bilik* by the researcher and local health staff. The group was divided into three subgroups, each under the guidance of a facilitator. In order to stimulate participation, encourage group interaction, and increase awareness among the participants of problems affecting the community, a game with plasticine models

Communities, if they are to implement projects, should be totally involved in the planning process.

was organized and dialogue sessions and focused group discussions were held. The participants were asked to create plasticine models of community members with health problems; a focus was thus created for initiating discussion on causative factors. This active approach gave the facilitators an improved insight into Berawan concepts of health. It was explained to the women that a survey was necessary to determine the extent of the problems. Guided by the facilitators they prepared a simple questionnaire on demography, housing, food availability and health problems. The survey was conducted by the women in a few hours, and they computed the data using simple addition and subtraction. The data were presented in a form that the women could understand (see table).

Survey conducted by village women

Households surveyed	57
Total number of people surveyed	408
Children under 5 years	55
Households with no latrine	9
Households with poor ventilation	46
Households growing vegetables	37
Households growing fruit	28
Adults with tuberculosis	9
Children with cough and cold	12
Children with diarrhoea	6

Problem identification

The women identified the main problems as ill health among children, tuberculosis among the elderly, poor ventilation and lighting, and difficulty in obtaining emergency care. They then worked with the women elders and village health promoters to prioritize the problems. Ill health among children was unanimously considered the most important matter, since the very young were regarded as the principal asset of the community. Furthermore, the participation of the women in the training course and the survey had given them the confidence and commitment needed for tackling ill health in children. Tuberculosis was ranked as less important because it occurred largely in the women's grandparents, over whom they had little influence.

Strategies for dealing with children's ill health were discussed. Certain strategies proposed by the researcher were dismissed as technically unfeasible or culturally unacceptable. Eventually the women agreed to set up a kindergarten and children's feeding programme, and they formed a health committee to plan and implement the project.

Programme planning

The health committee was encouraged to conduct a survey with a view to planning the kindergarten and promoting self-confidence, self-reliance, and commitment to the project.

The facilitators worked with the women to plan kindergarten activities and identify local human, financial and material resources. The women suggested several ways of harnessing community resources, and selected a kindergarten teacher, a headmistress, food supervisors and other workers. The women's criteria for selection differed from those of the researcher, who felt that the best candidate for the position of kindergarten teacher would be a mother with experience in child care; the women, however, selected a young girl because she had more free time. They also decided to involve mothers in food preparation. A demonstration of the children's feeding programme, in which volunteers prepared food from locally available, inexpensive, nutritious and culturally acceptable sources for 40 children, revealed the ease of implementation when a team approach was adopted, aroused community interest and motivated the participants.

A kindergarten committee was formed and the headman was made its chairman because of his ability to gather support. The head of the women's health committee, a primary school teacher and the headman's daughter-in-law, was appointed headmistress. An advisory committee comprising staff from the agricultural, health and community development agencies of the district government was formed to provide technical support.

Community assembly

The proposed plan was presented by the head of the women's health committee to the villagers at a community assembly. The rationale for the project and the need for self-reliance were stressed. The villagers were assured that there would be full technical support from the health team, and to underline this point all the materials brought in to start the kindergarten were displayed. The community went through the whole decision-making process and finally agreed to provide labour and subscribe to the kindergarten.

Pre-implementation phase

The headmistress was made responsible for implementation. Preparatory activities included: conversion of an unused hut into a kindergarten and construction of furniture by the men; registration of preschool children; preparation of educational materials; and organization of a kitchen and duty roster for the feeding programme.

Training was conducted locally to inform workers about child health and to give them skills so that they could perform specific tasks. Village health volunteers provided training on simple promotive care, while the research team covered management, record-keeping, organization and communication. The training process included talks, demonstrations, focused group discussions, role-playing, individual assignments and practical exercises. The participatory approach helped to build confidence and develop leadership. Training lasted four weeks and was conducted in the evenings, just before the harvest season, so as to avoid disruption of the usual socioeconomic activities.

Women in rural communities possess particular skills and capabilities and may have clearer ideas than external agents about the feasibility and viability of projects.

Implementation

The kindergarten and feeding programme came into being after three months of detailed planning. The activities included education in nutrition and personal hygiene, the teaching of basic skills, growth monitoring, and screening for illnesses. Mothers were rostered to prepare meals under the guidance of a food supervisor. Rice, vegetables, fruit and firewood were supplied by the mothers. Funds for the project came from local self-financing activities, such as the sale of cakes to the nearby school, and in the form of regular subscriptions from parents. The kindergarten teacher was paid a salary to ensure her full commitment and accountability to the community. The project was managed by the women themselves, who held frequent meetings to discuss problems.

Management should be decentralized so that locally organized committees have the responsibility and authority to run and adapt projects in response to community needs and changes.

Monitoring and supervision

A monitoring mechanism was established locally and centrally to assess progress, identify problems, and find quick practical solutions. At local level the kindergarten teacher proved capable of maintaining records and carrying out her teaching activities. Records of the utilization of funds were maintained by other workers. The headmistress provided local supervision, while monitoring at the intermediate level was done by the researcher, the local community health nurse, and the field agricultural officer, who made frequent visits during the first few months following implementation. Besides providing opportunities for learning, these visits enhanced the women's prestige and consolidated community confidence in them.

Some problems encountered during the early part of the implementation phase included food shortages due to drought, some parents' inability to pay for kindergarten services, loss of interest in the kindergarten, and rejection of the kindergarten teacher by some mothers who indicated a preference for a better-qualified person. Prompt action was taken to develop new recipes based on dried peas, which had the advantage that they could be stored. Poorer mothers were exempted from payment; they compensated for this by taking more turns in preparing meals. The mothers were assured of the teacher's potential, and this person subsequently received formal training from the community development agency.

As it was intended that the project should become self-sustaining, later supervisory visits focused on problem-solving and the broadening of the women's abilities. Weekly and fortnightly visits were made during the first two months; subsequently the intervals were extended to three months.

Evaluation

Evaluation was performed by the researcher and her team about a year after the project was established. The village women participated so that they could assess progress for themselves and introduce modifications to suit their needs. Maternal participation in the feeding programme amounted to 93.6%, while an average rate of 61.6% was maintained for kindergarten attendance. There was an increase in the proportion of households producing vegetables and fruit from 64.9% and 49.1%

to 87.9% and 93.1% respectively, probably reflecting the demands of the feeding programme. Weight-for-age improved in most of the kindergarten children and they presented a cleaner appearance. Many children have begun wearing shoes since the project was implemented. However, the absence of a control group makes it difficult to interpret the above findings. An indirect effect was seen on mothers' child-feeding practices: the percentage of women who breastfeed increased from 69.9% to 90.9%; only 9.1% of infants were solely bottle fed as compared to 30.1% prior to the project. Fruit, vegetables and fish were introduced as weaning foods. These changes may have been due partly to the kindergarten project and partly to an earlier primary health care project *(2)*.

The capability and self-reliance that developed among the women were important but unquantifiable. They became able to supervise, organize and coordinate project activities. They learned how to approach the nearby school for logistical support and have taken it upon themselves to register a new batch of children for the kindergarten.

The project is now monitored by the local community health nurse, and the researcher is following it up to assess its sustainability.

* * *

This project demonstrated that rural women could identify and act on community needs. On a basis of simple health training and local technology, women with only four to six years of schooling were organized to plan and manage a self-help scheme.

Success was largely attributable to an active, participatory approach and to community preparation as a prelude to involvement in planning. A major effort was directed to making the women aware of problems affecting their community and of their potential for self-help. The researcher did not impose her values and ideas on the women, was sensitive to community views, and endeavoured to build on and adapt to them. She helped to speed up the learning process and to generate confidence, enthusiasm and commitment, and motivated the women to address their health needs. Once community commitment had been won, planning based on locally identified and understood needs was carried out in cooperation with the women.

The maximum possible use of local resources and the efforts made to build abilities in the women contributed to the sustainability of the project, because dependence on external support was thus avoided. The unique design of the longhouse, with the close proximity of the households and the rather homogeneous, well-organized and close-knit structure probably also helped to get the women involved.

The men were drawn into the process: they constructed the kindergarten and made the decision that the community should subscribe to it. It is often said that men may not support women in development efforts as a result of misconceptions about roles, but in this project the men gave full backing to the women, probably because they recognized their essential function in child care. An additional factor was that the facilitators worked within community structures to sensitize men about the potential of women.

We suggest that the following points are worth special attention by anybody planning community-based projects involving women.

- Women in rural communities possess particular skills and capabilities and may have clearer ideas than external agents about the feasibility and viability of

projects. This should be recognized by planners.

- Communities, if they are to implement projects, should be totally involved in the planning process. It is therefore important to allot time to the preparation of communities and to cooperate with them in detailed planning.
- Close and continual monitoring, supervision and support by the external agents promoting change are essential, particularly in the initial stages of implementation. Problems can thus be solved on the spot. Furthermore, local health workers are enabled to develop, improve and learn new skills so that their autonomy and the sustainability of projects are increased.
- Management should be decentralized so that locally organized committees have the responsibility and authority to run and adapt projects in response to community needs and changes. This ensures local commitment. Decentralization of management does not, however, mean leaving projects to run on their own. It is still vital for other levels of the health and health-related systems to provide training and advisory and logistical support. □

Acknowledgements

We thank the International Development Research Centre, Canada, and the Institute of South-East Asia Studies for supporting the research project on which this paper is based. We are also grateful for the support lent by the Director of Medical Services, Sarawak, and for the kind help of Ms Lim Jock Hua, Ms Ng Peng Tiew, Ms Liong Yuen Yen and the health staff of Miri Health Office. We wish to thank the people of Long Jegan for their initiatives and all the other people too numerous to name, who contributed to the project.

References

1. **Heinrich, S.** Decentralization for rural development: government approach and people's initiatives in Asia and the Pacific. In: Bhat, A. et al., ed. *Building from below: local initiatives for decentralized development in Asia and the Pacific, Vol. 1.* Kuala Lumpur, Asian and Pacific Development Centre, 1987, pp. 1–40.
2. **Chen, P. C. Y. et al.** *Primary health care among the Orang Ulu of Sarawak, Malaysia.* Kuala Lumpur, Department of Social and Preventive Medicine, University of Malaya, 1989.
3. **Chen, P. C. Y.** Health care in Sarawak's jungles. *World health forum,* **10**: 190–192 (1989).

The longhouse at Long Jegan, Sarawak.