

# Annual Report

## HBP Bihar-Jharkhand 2005

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*Compassion wherever there is suffering*

*Conviction that the compassion is strong enough to*

*eliminate suffering*

*Courage to make this conviction a reality*

*...This is AID*

## 1. Introduction:

The HBP program is currently active in 9 blocks of Bihar and 2 blocks of Jharkhand and has been mostly focused on children and women health. The main aim of this program is to bring about a significant and measurable change in the health status of women and children and to improve the utilization and quality of government health services.

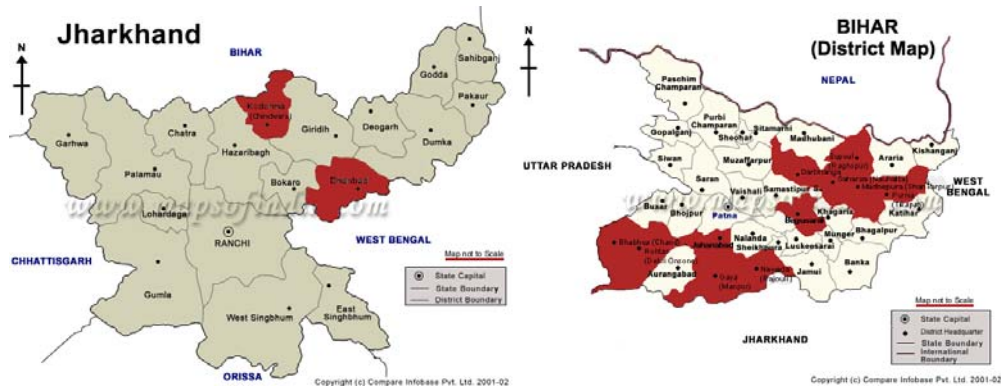


Fig1. Districts in Jharkhand and Bihar where HBP is being implemented (in red).

## 2. Goals of the Hundred Block Plan program

- 1.1. Measurably improve the health status of women and children.
- 1.2. Improve utilization of existing government health services.
- 1.3. Restructure and redesign government health services and programmes to make it effectively reach the poorest.
- 1.4. Educate people on health, nutrition and sanitation.
- 1.5. Create a community health worker and a team of health activists in every village who can locally plan for health needs of the village.
- 1.6. Make people see that the struggle for health is a part of the larger struggle for social change and equality – for without these changes a truly healthy life is not possible.

## 3. Current status:

HBP started in Bihar and Jharkhand in July 2002 in 14 blocks. After poor performance of some of the blocks a warning meeting was held in 2003 and in 2004 the entire funds to

the HBP Bihar-Jharkhand were stopped with the understanding that in 2005 only those blocks that improved their performance would receive funds . In 2005, 11 blocks are being funded; the 4 blocks that have been dropped are - Tundi (Dhanbad, Jh), kusheshwaraSthan (Darbhanga), dendari(Begusarai) and Tikapatti/Rupauli (Purniya). Following sections give a progress report of the program in the 11 active blocks.

### 3.1. Health status:

Second round of weight measurements of children below the age of five was completed in all blocks in July 2005. Following the second round of weighing, the data from the two rounds were consolidated and the short-term impact of the program was tabulated. Although the time interval between the two rounds of weighing is short, some clear trends were noticeable. For example blocks with a larger fraction of women volunteers did considerably better than those blocks with more male volunteers. This is mostly because women volunteers were better received when they went door to door to talk to mothers with young children.



The changes in child malnutrition observed between two phases of the weighing process were compared for all 9 blocks in Bihar. In Figs. 3 - 16 we have shown the child nutrition status and the changes in malnutrition state from one grade to another for all nine active blocks of Bihar. Based on their weight the children of each block were divided into 5 grades; normal and four grades with increasing levels of malnutrition. In our analysis grades I and II were designated as malnourished and grades III and IV were designated as severely malnourished.

### Children's nutritional status in Rajauli

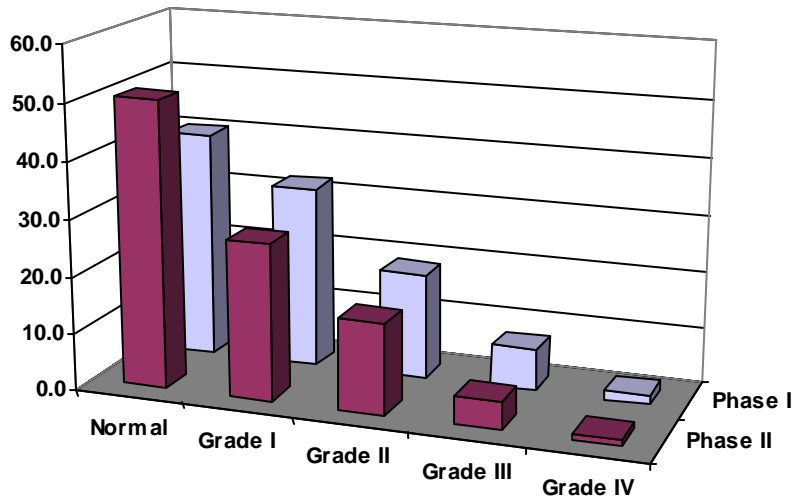


Fig 3: Shows the percentage of children in the different grades of malnutrition in Rajauli

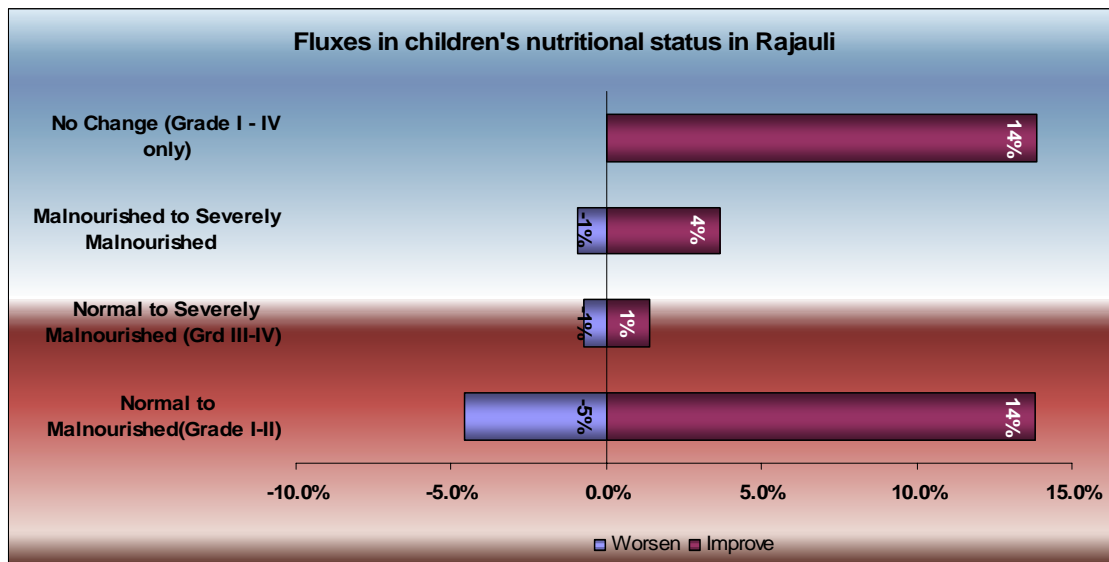


Fig 4: Shows percentage change of children in the different grades of malnutrition in Rajauli

### Children's nutritional status in Dehri

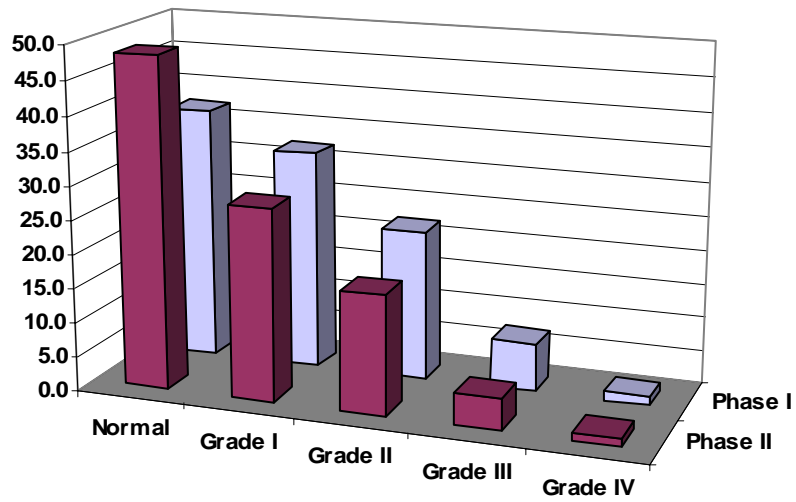


Fig 5: Shows the percentage of children in the different grades of malnutrition in Dehri

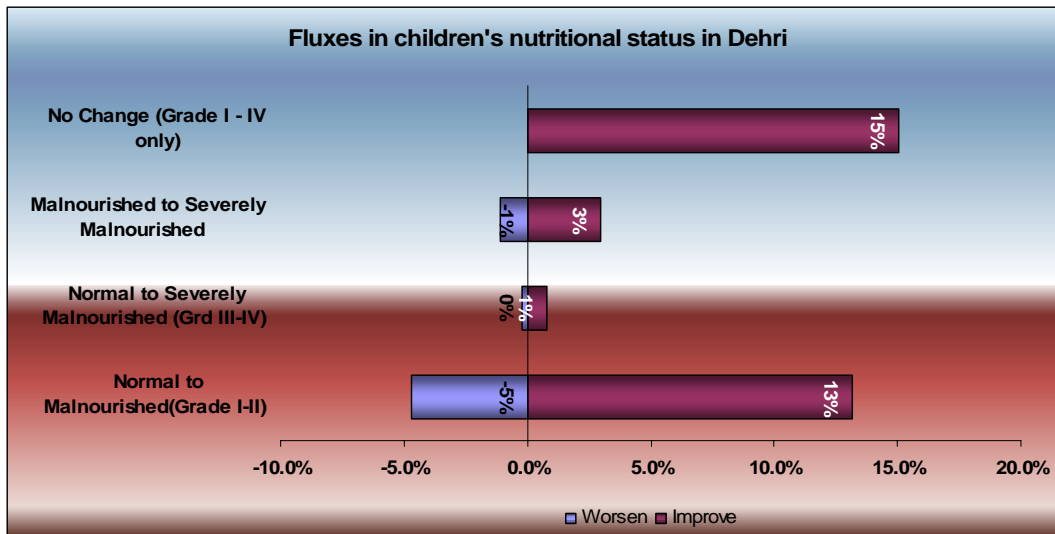


Fig 6: Shows percentage change of children in the different grades of malnutrition in Dehri

### Children's nutritional status in Jehanabad

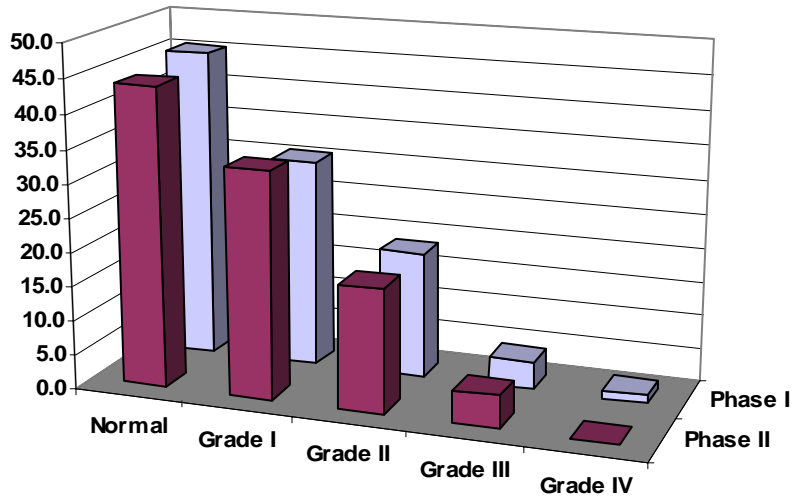


Fig 7: Shows the percentage of children in the different grades of malnutrition in Jehanabad

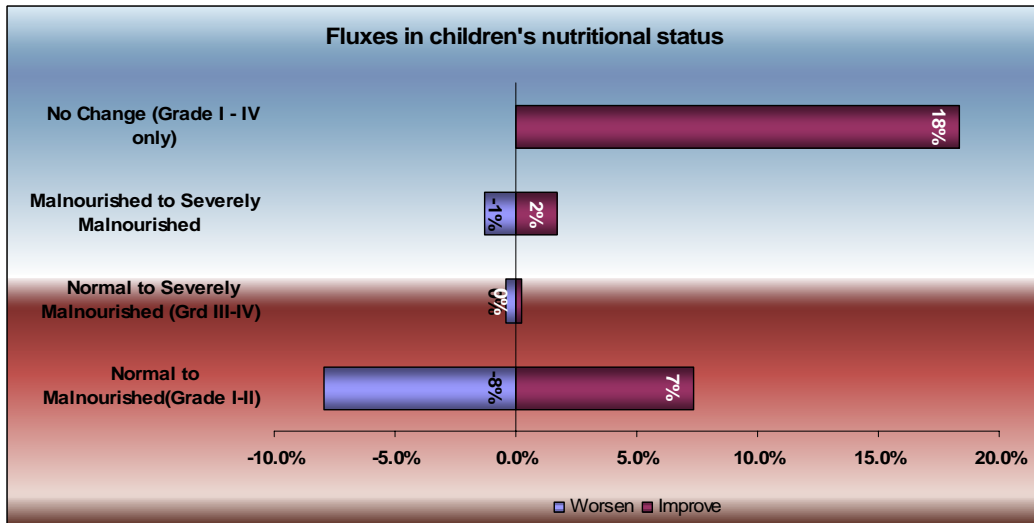


Fig 8: Shows percentage change of children in the different grades of malnutrition in Jehanabad

### Children's nutritional status in Makhdumpur

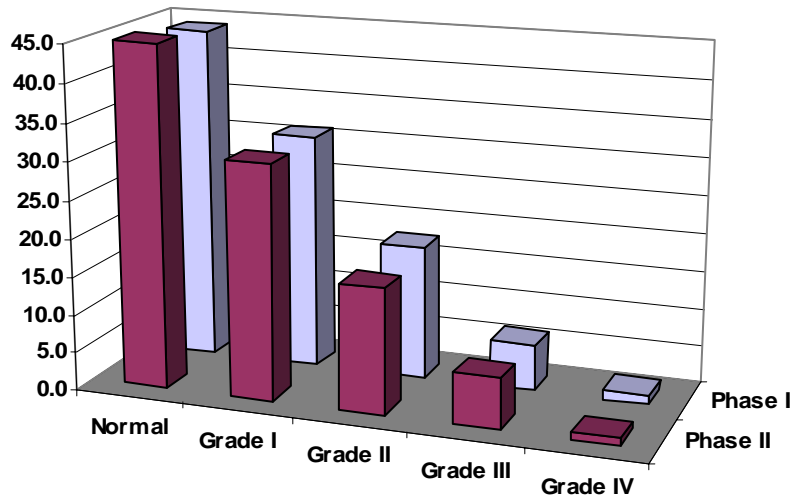


Fig 9: Shows the percentage of children in the different grades of malnutrition in Makhdumpur

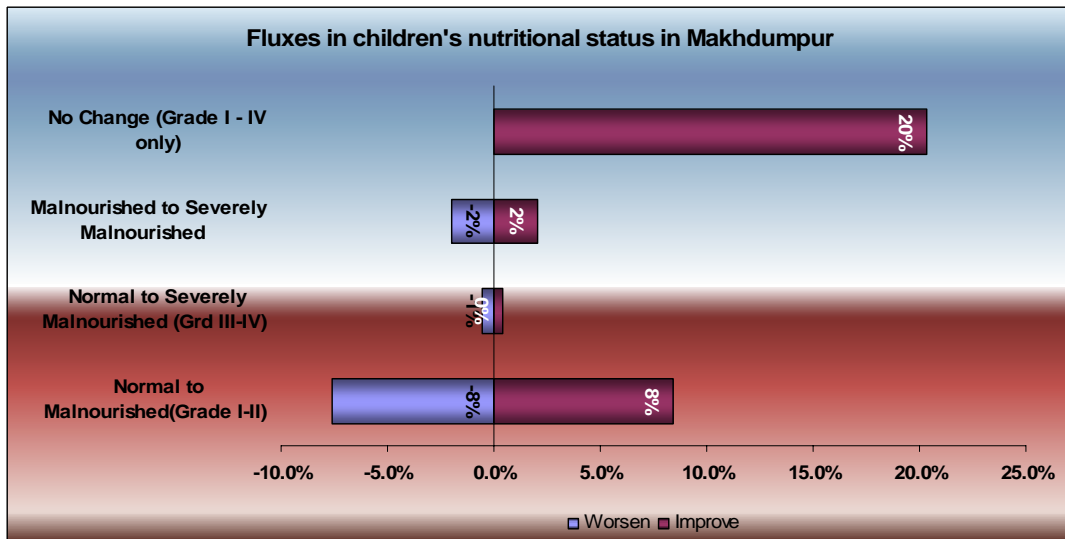


Fig 10: Shows percentage change of children in the different grades of malnutrition in Makhdumpur

### Children's nutritional status in Kishanpur

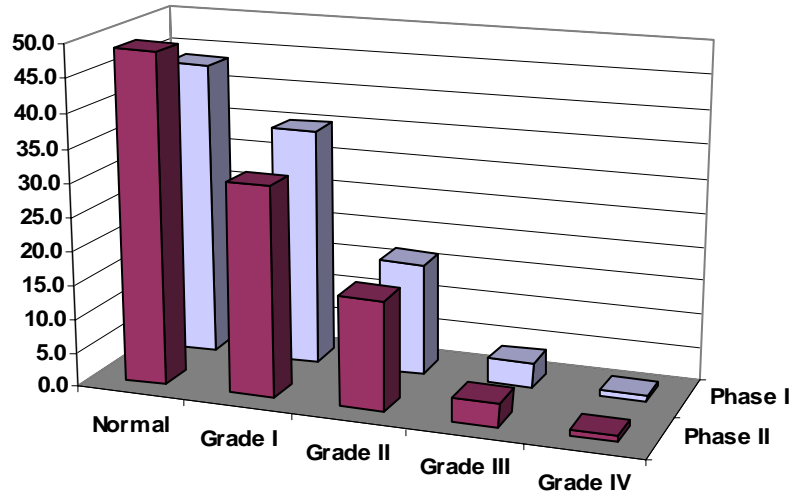


Fig 9: Shows the percentage of children in the different grades of malnutrition in Kishanpur

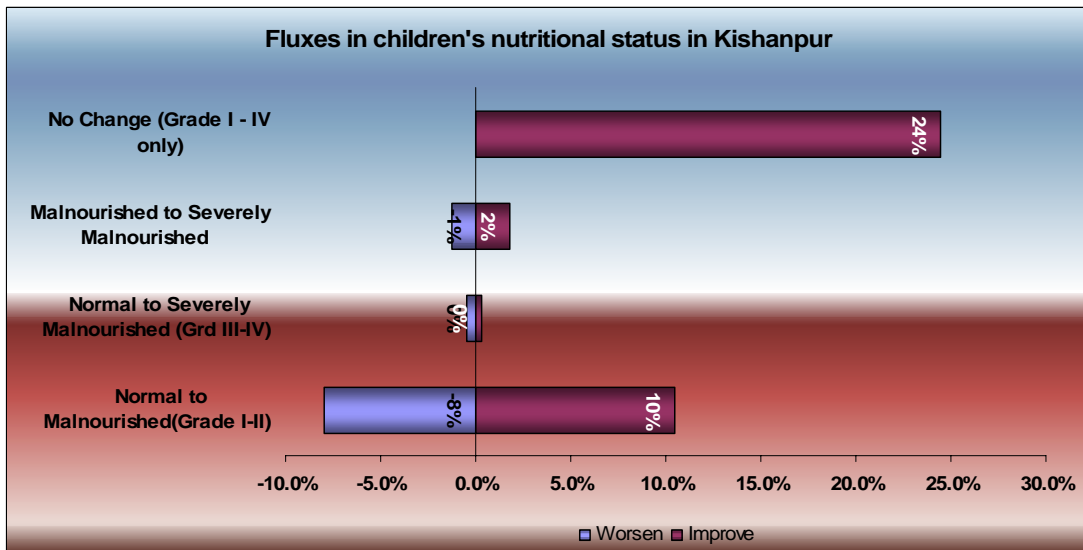


Fig 10: Shows percentage change of children in the different grades of malnutrition in Kishanpur

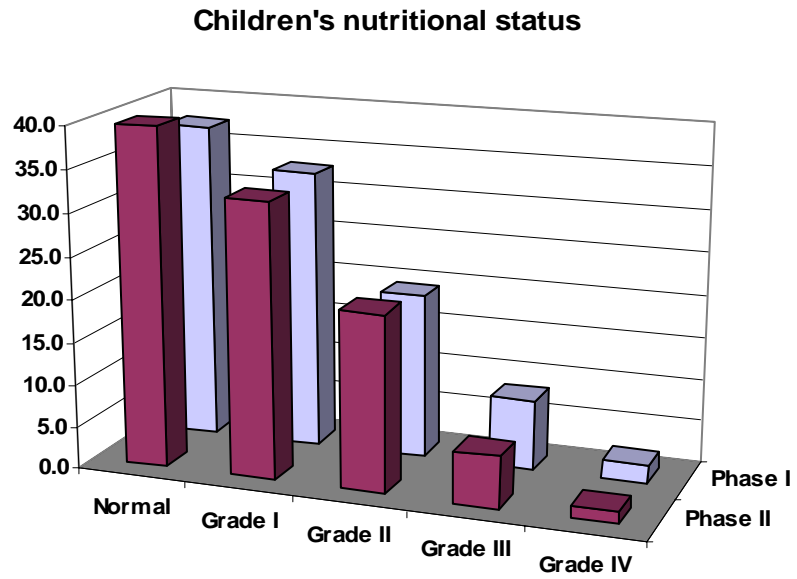


Fig 11: Shows the percentage of children in the different grades of malnutrition in Chand

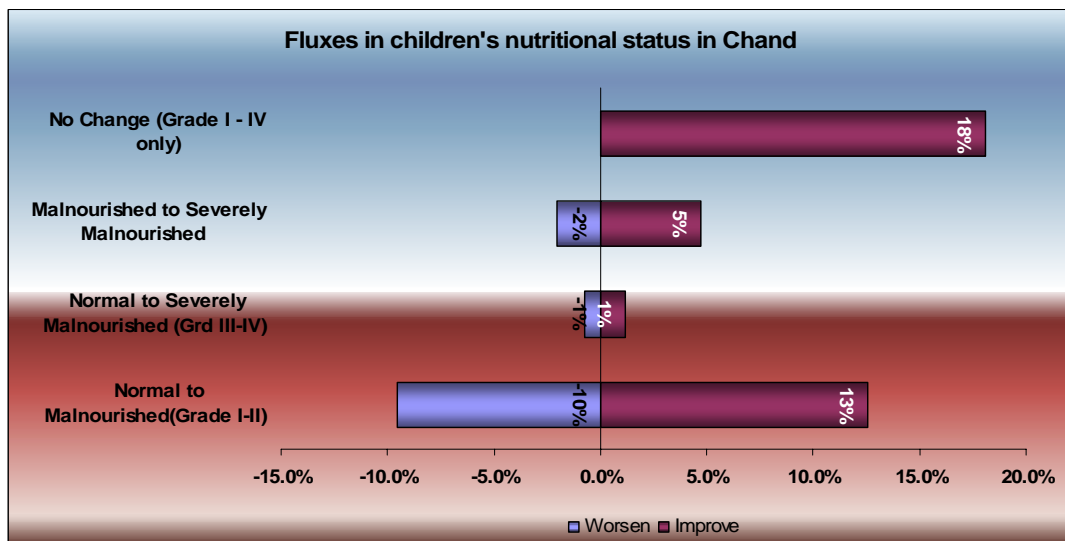


Fig 12: Shows percentage change of children in the different grades of malnutrition in Chand

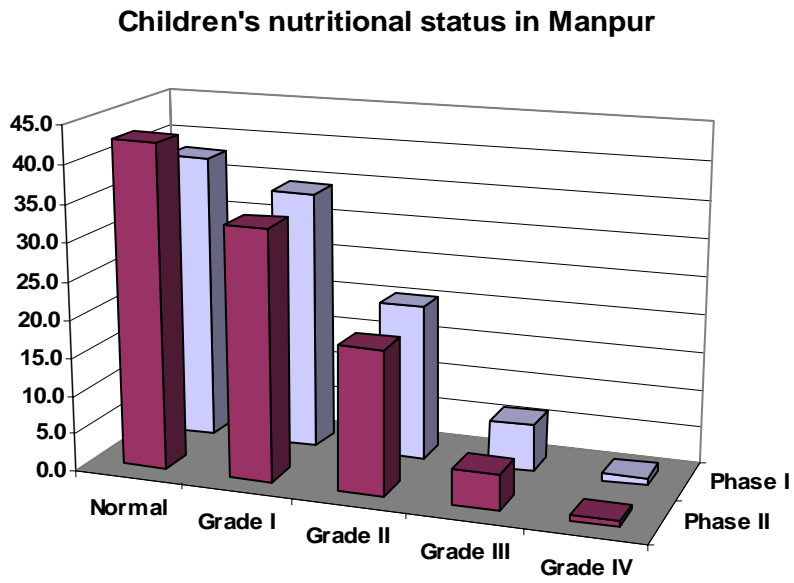


Fig 13: Shows the percentage of children in the different grades of malnutrition in Manpur

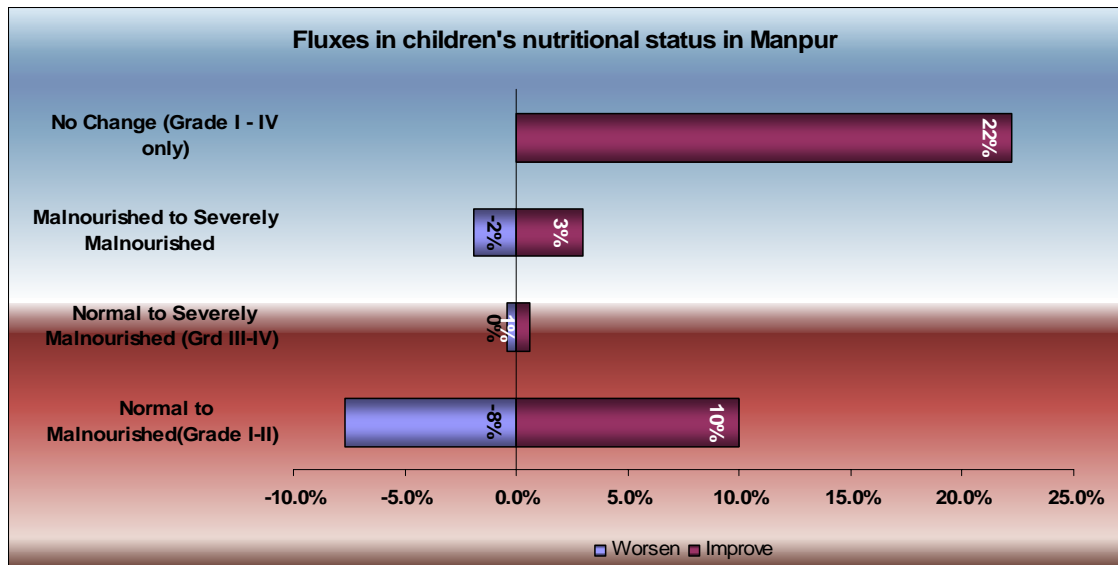


Fig 14: Shows percentage change of children in the different grades of malnutrition in Manpur

### Children's nutritional status in Patarghat

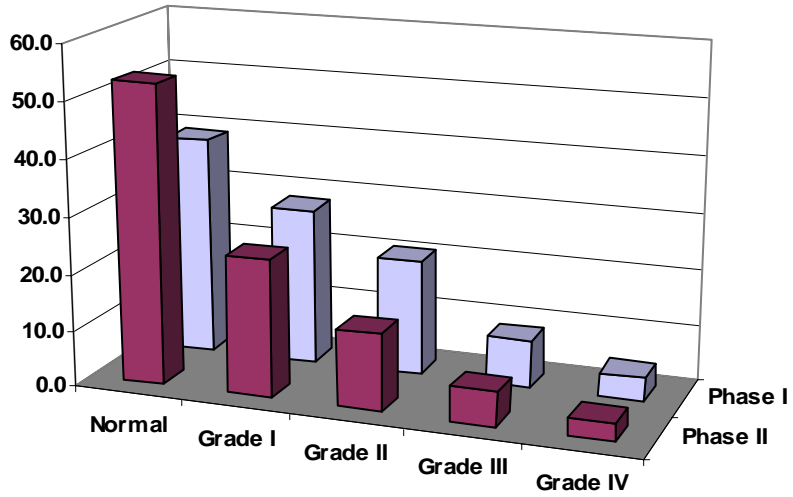


Fig 15: Shows the percentage of children in the different grades of malnutrition in Patarghat

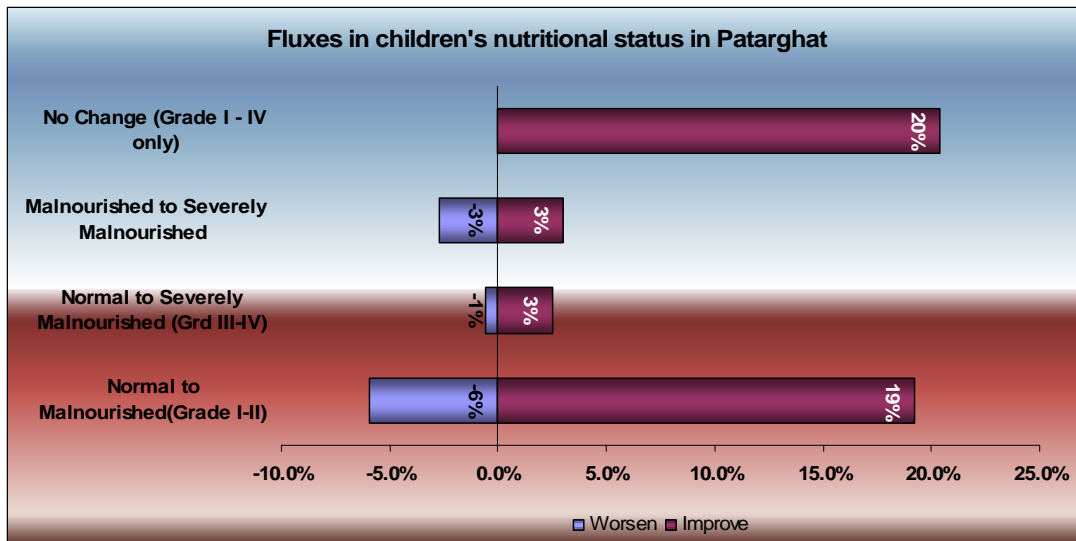


Fig 16: Shows percentage change of children in the different grades of malnutrition in Patarghat

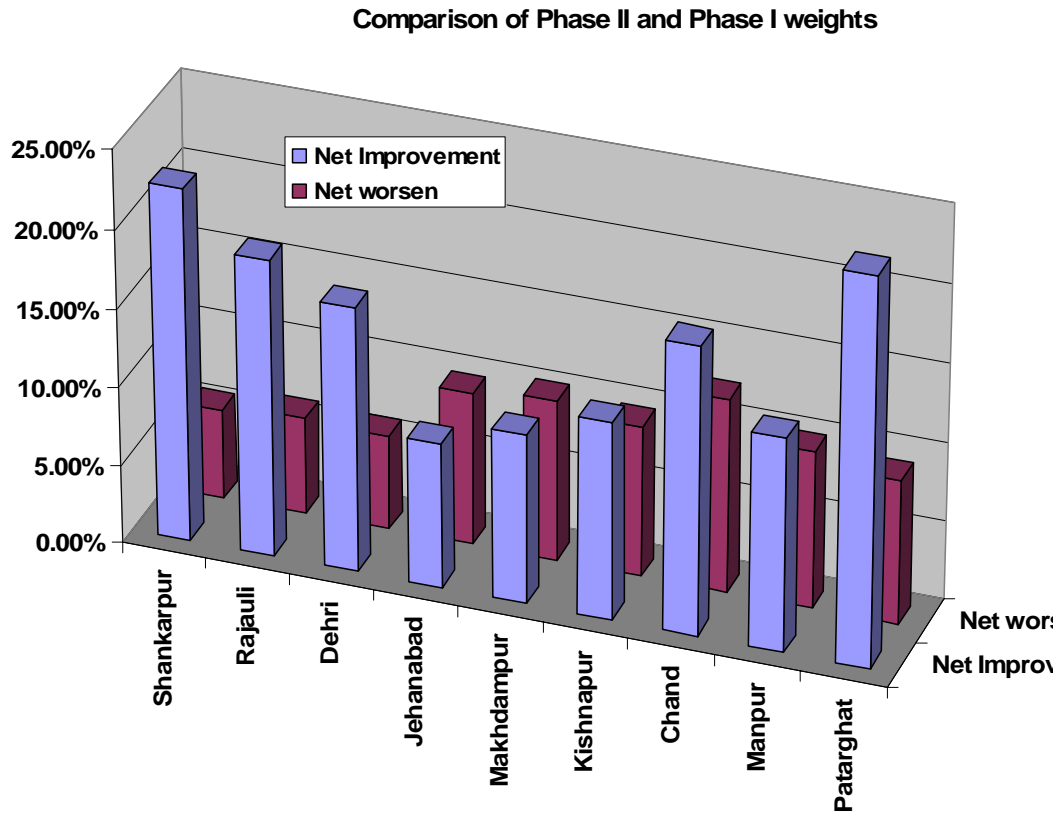


Figure 17 above summarizes a block wise breakup of net change in the nutritional status of children 'Under 5 yrs', in the 9 blocks of Bihar, between phases II and phase I of weighing.

### 3.2. Training on health, nutrition and sanitation

During June and July, 2005 training was provided to field workers in nine blocks - Dehri, Chand, Jehanabad, Makhdumpur, Patarghat, Shankarpur, Kishanpur, Rajauli, Manpur. The preparation work, meetings and formation of committees, was done in June 2005.

The second round of weight measurement was completed in July 2005 with field trainers and activists going door-to-door and reaching up to the villages. Data collected during this period was consolidated and additional training material was prepared from July 10 through 12. This material was published and used in the block training camps.

Training at the camps was in two forms - Campus Training that comprised

questionnaires, presentations, and role-play to discuss general issues in malnutrition and Field Training in which a specific case of malnutrition was discussed in detail. Issues covered included woman and child's health, infant diet, immunization, types of malnutrition, children's diseases, nutrition, self-help groups, and goals of the training program.

Dharmendra, Sarita, Dinesh, Anita, and Awdhesh were the main resource people at each site. It is encouraging that majority health workers are women in these blocks. In most



**Fig 8. Health Training camps organized in several blocks in Bihar**

cases, the local school, place of religious worship, or community hall was selected as training center, and the Police Incharge, Block Development Officer, or the local Mukhiya was invited as the chief guest or the inauguration celebrity. In blocks such as Patarghat and Manpur where the HBP program is going well, the field team members were complimented for their efforts. In blocks such as Kishanpur and Rajauli where the

program was found lacking, more training and specific tasks were provided. In Jehanabad, a two-day residential workshop was organized by AID-India and BGVS from July 23 through July 25, 2005. In this workshop, social justice and health issues were discussed with emphasis on the need to implement Central Government Program of National Rural Health Mission. Training was provided to dozens of participants on prevention of various child diseases. In Manpur, a two-day block level training workshop was organized by BGVS on August 5, 2005. Training was provided to health workers from 50 villages and discussions were held on issues of women and child health, malnutrition, disease, and poverty.

#### **4. Challenges and Lessons**

First, such a large-scale activity of targeting malnutrition among children in over 500 villages across two remote and underdeveloped states in North India is a unique

experience for AID and is a very exciting development. The logistics to implement the program exactly as planned were very challenging and significant hurdles were encountered. As a result, where weighing-counseling and follow up weighing had to be time-bound and done in a relatively short span of time of a couple of months, it actually took much longer. As a result, it is not clear whether the measured improvements were due to the specific interventions of this program or due to other variables that we did not consider as part of this effort. Inability to complete the weighing-counseling-weighing cycles in a time bound manner as planned has led to a lot of introspection. It was found that not all blocks had the optimum resources to undertake these tasks. Moreover, spreading the existing resources too thin was an issue. After substantial discussion between our grassroots partners and AID volunteers, it was decided that the next phase would focus on a smaller number of villages and there would be more support for the program in the form of training, monitoring on the job and intensive feedback and coaching. This effort is currently underway. Some volunteers from the US have returned to India with a specific goal to help this program keep on track.

However, it is very encouraging that quantifiable improvements can be demonstrated over a relatively short period of time. This program has emphatically shown to AID volunteers in particular and to all who are interested in public health in India, the grave proof for rampant malnutrition in our villages. Nearly 2/3rds of children in this sample of 500 villages were malnourished. This finding echoes other studies on childhood malnutrition in the past.

Lastly, while making a measurable improvement in children's nutritional status is a primary goal, there are a number of positive fallouts from the way this program is implemented. For example, bringing together women in weekly meetings to discuss health-related issues has helped the women of Madangundi (Koderma block, Jharkhand) to confront drunkenness and domestic abuse in their village. Similar strength in numbers enabled Muneja Khattoon of Pipra Di village, a brave village health activist to stand up against fundamentalist forces in her community. Counseling villagers about the available services from the local primary health center has encouraged the villagers to take advantage of these while building some pressure on the healthcare providers. It is now

more common to see the health worker show up in the villages, doing rounds more regularly than before. Such positive developments are commonly encountered by our volunteers who have kept up with the grassroots and constitute an extremely encouraging aspect of this program.