Health & Rights

Committed to Improving Sexual and Reproductive Health and Rights (SRHR)

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How to contain population explosion

According to prestigious "New Scientist" magazine, in just 6 hours from now there will be 50,000 more people in the world, and another 50,000 in the following 6 hours, and so on. This magazine thinks population is 'the single biggest problem facing our world.' There are nearly 7 billion humans alive today, with 75 million more being added each year. UN predictions say there could be an extra 2 to 4 billion of humans by 2050.

Earlier this year, the chief scientific adviser of UK Mr. John Beddington talked about a population-led global crisis by 2030. Even Bill Gates identified overpopulation as the greatest threat facing humanity.

Lack of education, lack of public health facilities, and inadequate infrastructure contribute to high birth rates. International experts believe that the way to reduce fertility involves a cultural shift towards improving the education and status of women, making family planning methods more widely available.

Almost all the developing countries have ongoing family planning programmes, but in most of these countries including Bangladesh they badly need renewed support. It is needless to say that there has to be a recognition of the importance of vigorous population control and of the importance of reducing birth rates at the highest political level. And for better result, it has to be linked to family health and welfare programmes, to primary education and to more opportunities for women to participate in income generating activities.

The need for family planning and population control is well reflected in the following findings. A seminar report of Gazipur Municipality and an international development organisation named Practical Action says that by 2020 the slum dwelling population in the urban areas of the country will reach the staggering figure of three (3) crore. Dhaka being the capital city it is most likely to be hit harder. Country's demographic chart shows that already about 30 percent of the total population live in various urban areas. The living condition in these slums is extremely unhealthy and unsafe. With poverty and unemployment in the rural areas rising alarmingly, more and more people are drifting towards the towns and cities in search of work and once in the urban areas it is only obvious that these people with marginal income will find cheap living accommodation in the slums. Dhaka is already faced with multi dimensional problems with a population of over one crore. The family planning campaigns among the slum population is not adequate. Therefore, further rise in population, especially in the slums, will create severe health, water, transportation and law and order situation for the future residents.

Performances of the SRHR consortium project:

Comprehensive reproductive & sexual health programme including MR services, training and BCC

The SRHR consortium-RHSTEP and BAPSA have been providing reproductive health services in the country in various locations since the early eighties. The services provided by this consortium are comprehensive reproductive health care services with safe MR service and treatment of abortion complications. To develop skilled personnel comprehensive MR training, RTI/STI training, Infection prevention management training etc are being conducted by the consortium. Besides training and services, BCC & awareness creation activities are ensured by the consortium at different platforms for raising the level of knowledge and awareness on SRHR. Introduction of such services brought a new dimension in RH services, created a ripple among the community and earned confidence of the community. Based on this experience, the consortium intends to continue the services in the existing areas and expand in some new areas with the financial support.

To address the Sexual & Reproductive Health & Rights issues in the context of Bangladesh, the SRHR consortium is delivering services in various administrative areas like divisions, districts, upazilas and unions under the project titled 'Comprehensive Reproductive & Sexual Health Programme including MR Services, Training and BCC (Comprehensive RSH Programme)'. This is a three-year project that started from July 2007 and designed to be completed by June 2010. This project was proposed to implement the SRHR services with the Swedish support. In this consortium RHSTEP is the Management Agency (MA) and the recipient of funds from the donor agency. The MA is responsible for ensuring effective implementation of the project as well as disbursement of the fund to other partner NGO as per budget allocation.

Goal of the Project

The goal of the project is to contribute towards improvement of Sexual and Reproductive Health Rights (SRHR) of women and adolescents and reduction of maternal mortality and morbidity to help fulfil the HNPSP targets of achieving health-related MDGs 4 and 5 in Bangladesh.

Objectives of the Project

i. To increase access to and utilization of quality reproductive and sexual health care services, especially services for MR and for management of unsafe and complicated abortion with back-up support to combat unwanted pregnancies;

ii. To strengthen capacity of the GO and NGO service providers in delivering quality MR and other SRHR services through comprehensive and refreshers training;

iii. To increase awareness and sensitize the community and policy makers;

iv. To orient the front-line health and family planning workers on SRHR and consequences of unsafe abortion and prevention of septic abortions;

v. To increase awareness and accessibility of the adolescents in SRHR services and about the consequences of unwanted pregnancies and abortion complications;

vi. To create community awareness on RTI/STI & HIV/AIDS through special BCC programmes;

vii. To establish referral linkages with higher hospitals, legal and social organisations working for SRHR;

viii. To encourage male participation in SRHR activities.

Major Components of the Project

Major activities of the project consist of two categories of services i.e. a) Clinical and b) Non-clinical.

Clinical Services

For improving the reproductive heath of the underserved urban and rural population. The consortium for the last two decades has been providing quality reproductive health care services through clinical services throughout the country. The consortium has expanded its services to Chittagong Hill Tracts (CHT).

The services provided by the clinics are as follows:

- Comprehensive MR Training for Doctors
- Comprehensive MR Training for FWVs/Paramedics
- Refresher MR Training for Paramedics.
- RTI/STI Training
- Staff Development Training
- MR Counselling
- MR Procedure
- Follow-up visit of MR clients
- Post MR contraceptives
- Contraceptive services for non-MR clients
- Follow-up of contraceptive services
- General Health Care (Limited Curative Care)

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- Maternal Health Care
- Post Abortion Care
- Management of other OB/Gyn problems
- Adolescent Reproductive Health Care
- Pap's Smear test
- Pap's Smear client follow-up
- VIA test
- Histopathology test
- Pathological service
- Ultrasonogram

Non-Clinical Services

The non-clinical services are mainly conducted by BAPSA and these are as follows:

- Maintaining Liaison and Organizing for MR basic and Refresher Training in close collaboration with the DGFP
- Organizing training for Doctors
- Organizing training for FWVs/ SACMOs/ Nurses
- Monitoring of distribution of MR equipment from the Ware Houses to the providers.
- Visit supply sources to assess the MR Equipment
- Monitoring of the quality care of MR services
- Orientation of front-line FP workers on unsafe abortion
- Holding community level meetings

Other activities

- Health Care services for Garment workers
- Community Health Care
- Prevention of HIV/AIDS Service
- Workshop/Seminar/Meeting
- Follow-up of MR Training Providers
- BCC/Advocacy Activities
- Publication of "Health & Rights" Newsletter

The Consolidate performance of the project

According to the joint project proposal RSH consortium had a number of targeted activities including clinical, non-clinical and BCC activities in the reporting period (i.e. July 2008 to June 2009). The quantitative performances are presented below against the set target of different activities. Here it is necessary to mention that both RHSTEP and BAPSA performed their activities as per their approved revised

Annual Target and Midterm achievement of Project activities Period: July 2008-June 2009

Sl. No.	Activities	Target	Achievement	%
1.	**Training**			
1.1	Comprehensive MR Training to Doctors	240	143	60
1.2	Comprehensive MR Training for FWVs/Paramedics	120	131	109
1.3	Refresher MR Training for FWV/Paramedics	260	189	73
1.4	RTI/STI Training	186	26	14
2.	**Services**			
2.1	MR Counselled	66,882	62,004	93
2.2	MR Done	63,462	58,038	91
2.3	Follow-up visit of MR Clients	38,360	28,094	73
2.4	Post MR Contraceptive Services	62,981	55,427	88
2.5	Contraceptive Services (Non MR Clients)	36,445	63,604	175
2.6	Maternal Health Care	27,820	36,244	130
2.7	Post Abortion Care	4,345	2,662	61
2.8	Management of other OB/GYN Problems	38,388	42,417	110
2.9	Pap's Smear Test	9,000	9,458	105
2.10	Pap's Smear Client follow up	7,000	6,598	94
2.11	VIA Test	3,600	787	22
2.12	General Health Care (Limited Curative Care)	59,276	86,836	146
2.13	Adolescent Reproductive Health Care	90,600	159,369	176
2.14	ARH Related Orientation Sessions	1,434	1,649	115
2.15	Health Care Services for Garments Workers	51,300	105,100	205
2.16	Community Health Care	30,000	44,489	148
2.17	Prevention of HIV/AIDS Service	8,040	11,498	143
3.	**Workshop/Seminar/Meeting**	195	748	384

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target and budget. The following progress report highlights the combined performances in the period of July 2008 to June 2009. In the reporting year the consortium implemented the project and it can be seen from the analysis of clinical and other service statistics of the consortium that except few components the performances of the project activities are more encouraging than the previous year. It is because that the consortium identified the weak areas in the past year and tried to bridge those gaps. In this reporting year more concerted efforts were given to organize community level programmes. Community level activities are now being given priorities in most development programmes. For the SRHR programme it can work as an impetus for the population to enhance their reproductive health related knowledge and encourage them to come to the clinic for services.

Sl. No.	Activities	Target	Achievement	%
4.	**BCC/Advocacy Activities** BCC/Out Reach (Approximate Population covered): a. Community based Awareness: In order to communicate all necessary information on safe MR Services Reproductive health of women including HIV/AIDS/STI/RTI, family planning method and MCH program through Audio/Video, signboard, bill board, poster etc. also group meeting/interpersonal communication in the community.	1,097,000	1,881,363	172
5.	**Publication of Newsletter "Health & Rights" (Bengali & English Version)**	60,000	65,000	108
6.	**Monitoring of the Quality care of MR services**	320	312	98
7.	**Orientation of front-line FP workers**	1760	1465	83
8.	**Holding community level meetings**	7,500	13,719	183

Quality of MR services: Providers and physical facilities

In this project, attempts were made to assess the quality of services provided by the FWVs at their union level clinics. For assessing the quality of care of services, the issues considered are: training, refresher training, current status of services, problems faced in providing services and in getting supplies of equipment, nature and type of problems etc. From the information collected by the MR providers, it appears that a total of 283 MR providers were interviewed and all of them are posted at Upazila and Union level Health and Family Welfare Centres. Out of 283 providers, there were 44 Medical Officers, 11 SACMOs and 228 FWVs. The key findings are as follows.

- The mean years of service of the providers in the FP department were found to be 22.22 years and almost 47.3% of them serving 21-30 years and over 35% for 11-20 years.
- The mean years serving in the present place of posting are 5.75 years for the providers.

Currently Providing MR Services

	Medical Officer		SACMO		FWV		All	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	1	2.3	6	54.5	209	91.7	216	76.3
No	43	97.7	5	45.5	19	8.3	67	23.7
N	**44**	**100**	**11**	**100**	**228**	**100**	**283**	**100**

- Out of the providers interviewed, 97% of FWVs, 82% of SACMOs and 68% of MOs received basic MR training.
- Almost 75% of MR providers received training from RHSTEP centres. The remaining numbers obtained training from MFSTC and other centers.
- It also appears from the collected information that the MR providers on an average received training 16.23 years ago.
- Currently Refresher Training is being organized for the FWVs and 82% of the sampled FWVs received Refresher Training.
- The mean past years of receiving the MR refresher training is found to be 8.57 years.
- Those who did not receive the refresher training, 60% mentioned about its necessity.
- Surprisingly out of 44 doctors, only one doctor was found to have provided MR services and 92% of the FWVs 55% of

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- Most frequently cited reasons for not providing MR are Religions/ social (28.4) and physical/personal disliking (19.4) and other personal problems. As mentioned by 4.5% of the respondents training is not sufficient.

Providers were interviews by designation

Providers	Number	%
Medical Officer	44	15.5
SACMO	11	3.9
FWV	228	80.6
TOTAL	**283**	**100**

- Ninety nine percent of the MR providers mentioned that they provide MR at office clinic. A similar opinion was expressed by 99.5% of the FWVs and 83% of the SACMOs respectably. A very negligible percent of the respondents mentioned about Private clinic, whereas 8% of the respondents mentioned about their own residence.
- Nearly 96% of the respondents mentioned about the procedural steps taken for client registration, (99.5%) pre-counselling, (63.4%) urine examination for pregnancy test, (99.5%) selection of the client and (99.5%) preparation of instruments.
- About the contraindications and problems associated with the MR services, the providers mentioned about: problem in uterus (44.9), hypertension (57.4), Jaundice (52.8), anemia (38.9), heart disease (37) and Caesarian operation (17%).
- On an average, the mean number of MRs done by the SACMOs during the last three months as reported by them were found to be 30.9% whereas half of this number was reported by the FWVs. The numbers reported by the doctors is insignificant being only four.
- Only 87.5% of the providers are maintaining record. While most of the providers maintain records, nearly 97% of them mentioned that they do not maintain records of those clients rejected for MR services.
- Eighty seven percent of the respondents mentioned that they rejected the MR cases during the preceding three months of the survey.
- On an average, 11.18% clients were rejected by all categories of providers in the preceding three months.
- The reasons for rejection as mentioned by them are longer duration (51%), medical reason (23%), gynaecological reason (12%), shortage of clinical facilities (11%) and primy cases (11%).
- Only one-fifth of the providers maintain complication register and also mentioned that 4.6 percent suffered from complications. And the nature of complications experienced by the clients are: incomplete MR, high temparetue, pain in lower abdomen, prolonged excessive bleeding, and menstrual disorder.
- As mentioned by 21% of the providers, incomplete MR / abortion cases were treated by other doctors /village doctors during the last three months. In total, 208 cases were treated by the providers.
- One fourth of the providers was found to be maintaining follow-up register, and on an average, 9.41% clients came for follow-up.
- Kinds of problems that were faced by the providers are: excessive bleeding, difficulty in determining the size of the uterus, tension felt during MR procedure.
- Ninety three 93% of the providers mentioned that they performed the monthly report.
- Ninety four percent of the providers mentioned that they were given method to their clients immediately following MR
- The mean number of clients given post MR contraception was 16.01%.
- Most frequently given methods are pill and condoms.
- In pre-counselling session, most frequently mentioned issues were:LMP (98%) query about first pregnancy, age of youngest child, query about first delivery (whether caesarian or not), assessment of the problems and contradication of M.R, information on MR, consent of guardian or husband etc.
- In post-counselling session, 88% mentioned that they advised the clients to take rest for 7 days, 76% advised not to do heavy work, 52 % advised to come to the clinic immediately in case of any complication, 82% advised to refrain from intercourse within 15 days, 52% advised to come for follow-up visits, 44% advised to use sanitary napkin, 77% advised to use FP methods and 77% advised to take medicine regularly.
- Most frequently mentioned source of supply was UFPO stores while only 1.4 % mentioned about market.
- Almost all the providers nearing 99 % currently have MR equipment.
- Most of the providers (95.4%) do not face any problem to get supply of MR equipment.
- The mean number of MR done by using one MR syringe was found to be 31.37.

Basic training on MR

	MO	%	SACMO	%	FWV	%	Total	%
Yes	30	68.2	9	97.4	222	81.8	261	92.2
No	14	31.8	2	2.6	6	18.2	22	2.8
TOTAL	**44**	**100**	**11**	**100**	**228**	**100**	**283**	**100**

- Goverment Order regarding how many MRs can be done by using one MR kit was mentioned by 59% of the providers.
- Mean number of MR performed with the last MR syringe received by the providers is 14.56%. Stock out incident was found to be almost absent.
- 80% facilities have electricity connection.
- 59% facilities have running water

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- Aya (maid) is posted at 76% of the facilities.
- Only 32%of the FWVS/SACMOs were found to be living at their clinic residence and those who are not living at clinic residence, 38% were found to live within 1 kilometer distance from the clinic and 25% within a distance of one to two kilometres away from the clinic as started by the providers.
- For providing quality services accommodation, equipment and medicament are prerequisites. All the providers have the necessary equipment at the clinic, but as reported by the providers, emergency medicines and other medicaments are highly insufficient

These are the important issues as identified during the one year intervention at various levels of the service providing system. If the mentioned issues are addressed properly, the quality of MR programme will improve markedly. For this, in the coming years, better GO-NGO collaboration and clients' needs should be taken into consideration.

Making the case for family planning

Modern-day family planning advocates need to marshal an array of arguments that appeal to current health and development priorities, including the MDGs. Key messages include:

- ***MDG 1: Family planning alleviates poverty and accelerates socioeconomic development.*** With fewer, healthier children to provide for, families are less likely to become poor. They are also better able to feed and provide health care for their children, which creates a healthier and more productive workforce that can contribute to the economic growth of the nation as a whole. On the national level, rapid population growth resulting from high levels of unmet need often outstrips economic growth and undermines a country's ability to offer adequate educational, health, and other social services to its people.
- ***MDG 2: Family planning can help ensure that all children go to school.*** Families are more likely to be able to educate their children if they have smaller families. For example, some girls are forced to drop out of school early to care for younger siblings. Girls and young women may also be forced to leave school early if they get pregnant.
- ***MDG 3: Family planning promotes gender equality.*** Women have greater opportunities for education, training, and employment when they can control their fertility. This can increase their financial security, Decision-making power in the household, and status in the community. Because so much of women's work consists of unpaid household labor and poorly paid work in the informal economy, their increased productivity may go unnoticed and unmeasured. Yet it is still of enormous importance for moving families out of poverty.
- ***MDG 4: Family planning can reduce infant mortality*** by one-Fifth To one-third or even more in some sttings. Spacing births 36 to 60 months apar reduces malnutrition as well as neonatal and infant mortality.
- ***MDG 5: Family planning reduces maternal mortality*** in there ways. It decreases the total number of pregnancies, each of which places a woman at risk. It prevents pregnancies that are unwanted and hence more likely to end in unsafe abortions, which contribute to one in eight maternal deaths. Finally, it reduces the proportion of births that are at greater risk of complications because of the mother's age, parity, or birth spacing.
- ***MDG 6: Family planning can slow the spread o HIV/AIDS.*** Condoms simultaneously prevent HIV transmission and unwanted pregnancy. Contraceptives also enable HIV-positive women to prevent unwanted pregnancies. This is as cost-effective as antiretroviral drugs in reducing mother-to-child transmission of HIV.
- ***MDG 7: Family planning can help protect the environment*** by reducing population and the pressures it places on natural resources, such as arable land, fresh water, timber, and fuel.

For more information on making the case for family planning, see Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care; Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals; Why Family Planning Matters; and "Repositioning Family Planning in Sub-Saharan Africa."

Source: Out look, Volume 25, Number 1, November 2008.

TOT on AYSRHR held in Dhaka in August 2009

The SRHR consortium (RHSTEP and BAPSA) organized a three-day Training of Trainers: Adolescent - Youth Sexual and Reproductive Health and Rights in two batches during 8-13 August '09 at Shaheed Maizuddin Auditorium, FPAB, Dhaka. A total of 56 participants from field level programmes of RHSTEP and BAPSA attended the training.

The objectives of the training were to:

- Introduce participants with the Adolescent Manual on Reproductive Health and Rights recently published by the SRHR consortium
- Train them on different tools and techniques to enhance the capacity conducting the education programmes at school and community level and counselling at clinic too.

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"Develop a trainer's pool among the participants on the basis of their pre and post evaluation performance and presentation skills.

The training covered the areas of adolescent, youth, teen age, young people, the changes during adolescence, national situation of young people, importance of addressing young people and SRHR issues, myths and facts on the changes, male & female organs and how reproductive organs work, sex, sexuality, sexual & reproductive health and rights, sexual abuse, violence, grey areas in violence, communication, peer education, counselling and life skills educations.

Different methodologies like power point

presentation, brain storming, plenary and open discussion, group exercise, demonstration and role play by the participants were followed in the training.

The training was conducted and facilitated by two resource persons from Family Planning Association of Bangladesh (FPAB) named Mr. Md. Moazzem Hossain, Focal Point (Adolescent) and Dr. Sufi Zamal, Deputy Director and Focal Point (Abortion).

At the end of the training, the participants were awarded certificates by the Executive Director of RHSTEP and the Director of BAPSA.

Consortium member visited BAPSA clinic at Rajsthali, Rangamati and Bandarban Clinic of RHSTEP

The SRHR consortium has taken the initiative to provide quality RH services at CHT to address their priority health needs. In part of this expansion, BAPSA proposed to intervene at Rajsthali Upazila of Rangamati. About two-thirds (65%) of the population of this upazila are indigenous. This upazila comprises three unions and out of them two unions with an approximate population of 15000 have been selected for the intervention. In the first year of the project attempts were made to collect the basic information and to understand the characteristics and attitude of the tribal population and also to assess their health needs. At that stage decision was taken to find out a suitable place for the clinical activities, and for hiring a building for the clinical activities. For creating more understanding at the community levels, volunteers were recruitted from within the community and planning of ground works were made successfully. The target populations are women and men of reproductive age, children and adolescents. For intensive working system the working strategies were proposed; clinical service operation through static and satellite team; BCC in cluster approach; referral of complicated MR and post abortion cases to district Hospitals based clinic of RHSTEP; recruitting service staff from local ethnic community; produce IEC materials and translate it into local languages; involvement of youths as volunteers; and ensure participation of tribal people and their power structure in project implementation. Following the completion of the ground works, all the services have been started to be provided and necessary manpower have been recruitted and trained. In-house training and on the job training was organised for providing better services to the clients at the clinic levels and at the satellite clinics. All the recording and reporting system has been established including financial ones. Thus the clinic is now functioning and has started serving in full swing from the middle of last year. On September 17, 2009, the consortium member and RHSTEP's Board member

and Secretary General, Ms Nazma Ayesha Akhter, Quazi Suraiya Sultana, Executive Director and Director Finance RHSTEP visited the clinic. Mr. Istiaq Joarder , consultant for strategic assessment, director and Training coordinator, BAPSA were also present. Dr. Subir Khiang Co-ordinator and Medical Officer of the Clinic with other staff met the guests. The visiting team then went to Naikhangchara, 8 km to the east of Bangalhalia Clinic, to see a satellite clinic and other community level activities of BAPSA. In the satellite clinic the patients were treated free with medicine. The team also observed the health education session at the community level which was run by the supervisor and the service promoter in the local language. The topic of the discussion was the importance of antenatal and post natal care. Different types of posters and flipcharts were used during the discussion session. Returning from the visit the team attended a discussion in the clinic with the staff and outreach volunteers. The lead agency highly praised the organized works at the difficult areas in a very short time and encouraged its continued. They wished a successful venture and to consolidate the services for serving the disadvantaged hilly population of Rajsthali Upazil; a of Rangamati of CHT. It is to be mentioned that the mentioned team also visited the Bandarban Clinic of RHSTEP. In this clinic broad array of services are being offered to the disadvantaged population of the Hilly Bandarban district. The clinic is located in the Sadar Hospital of Bandarban District.

Performance statistics

MR services

Type of centre	Last three months (July to September 2009)	Since beginning of financial year (July to September 2009)	Previous financial year (July 2008 to June 2009)
Training/Service centres (MFSTC, RHSTEP, BAPSA, BWHC, MSCS)	35,135	35,135	1,47,200

MR training

Name and Location of the Centre	Year of MR Training Facilities Established	Turnout of Fresh Trainees						Turnout of Refresher Trainees		
		July to September 09		July 2008 to June 2009		Total turnout		Jul to Sep '09	Jul 2008 to Jun 2009	Total turnout
		Doctor	Paramedic	Doctor	Paramedic	Doctor	Paramedic	Paramedic	Paramedic	Paramedic
MFSTC	1975	-	-	-	10	399	1,416	-	-	686
RHSTEP	1979									
DMCH	1979	14	4	30	14	1534	364	-	10	755
SSMCH	1979	-	4	11	10	1493	390	-	8	185
CMCH	1979	-	3	2	37	870	682	-	13	269
RPMCH	1980	-	-	21	9	1137	624	-	13	289
SBMCH	1981	2	3	11	6	1282	556	-	8	230
SMCH	1981	-	1	-	4	807	416	-	16	213
MMCH	1981	-	-	8	7	1008	700	-	11	193
PGH	1981	-	3	-	1	266	589	-	8	285
KMCH	1981	-	2	11	7	451	716	-	11	248
RIMCH	1988	-	-	13	4	696	290	-	12	283
NSH	1991	-	-	-	4	27	103	-	14	244
COMCH	1998	-	-	23	9	228	99	-	9	115
FMCH	1989	1	-	11	5	220	74	-	10	85
CBSH	1999	-	-	-	-	10	19	-	-	22
JGH	2001	-	1	-	2	7	9	-	-	19
MCD	2003	-	-	-	-	-	-	-	-	-
BMCH	2005	-	-	-	-	-	-	-	-	-
DIMCH	2005	-	-	-	-	-	-	-	-	-
MAH	2009	-	-	1	-	1	-	-	-	-
Total		**17**	**21**	**142**	**119**	**9,937**	**5,631**	-	**143**	**3,425**
BAPSA	1983									
MRHC-1	2002	-	-	-	-	-	-	-	57	272
MRHC-2	2002	-	-	-	-	-	-	-	-	-
RRHC	2002	-	-	-	-	-	-	-	-	5
Total		-	-	-	-	-	-	-	**57**	**277**
Grand Total		**17**	**21**	**142**	**129**	**10,336**	**7,047**	-	**200**	**4,388**

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