Rural Effective Affordable Comprehensive Health Care

(REACH)

ANNUAL REPORT 2014

SHARE INDIA

MediCiti Institute of Medical Sciences
Ghanpur Village, Medchal Mandal, Ranga Reddy District,
Telangana   - 501 401, India

SHARE started with a simple thought

Twenty eight years ago a seed of a noble thought was planted that would later on become a flourishing tree of health and happiness for a huge segment of people. That life transforming seed was SHARE (Science Health Allied Research & Education).

It was a handful of NRI professionals along with committed Indian philanthropist led by a visionary who had the dream to give something substantial and special back to their motherland as a token of gratitude. The focus was to bring in their vast wealth of expertise to serve community as a whole.

Choosing picturesque and peaceful environs, at Medchal Mandal (County) about 35 kms from Hyderabad, the Capital City of the State of Telangana , they went about their mission. Thus was born a world-class medical center which today, is a proud institution of health and happiness covering 40 villages and providing world-class care to the needy.

SHARE People Behind

SHARE is a brainchild of Dr. P. S. Reddy, Professor of Medicine, University of Pittsburgh and Chairman of SHARE. His vision is now being transformed into reality by a team of young and dynamic professionals.

Our Mission

To strive

- To increase knowledge.
- To impart knowledge.
- To apply knowledge.
- To provide quality and affordable healthcare for all.

One Goal: Health First

- To provide quality advance medical care at lowest possible cost.
- To develop a working model of Healthcare Delivery System for rural population.
- To promote undergraduate, graduate, post graduate and continuing Medical Education.

And above all

- To promote Research

Philosophy of SHARE

Nature has created a divided world of those who have the capacity to give and those who have the need to receive. We are the lucky few who are blessed with the capacity to give rather than receive. Let us thank God for giving the capacity and opportunity to give by giving.

EXECUTIVE SUMMARY

REACH (Rural Effective Affordable Comprehensive Health Care) is a project of SHARE (Science Health Allied Research & Education) India, a US-India cooperative non-governmental organization initiated to bring health care to the community, utilizing trained village based community health volunteers (CHVs), with particular focus on prenatal care of pregnant women, child immunization, and family planning interventions.

Aims

The main aim of the REACH project is to provide integrated maternal and child health, family welfare and primary health care services to the rural population involving the community to achieve a reduction in the morbidity, mortality and fertility levels. The aim also was to develop a dynamic data base on all the households pertaining to pregnant women and infants and children with the help of the CHVs, which is subsequently validated and updated by the Health Supervisors and Field Coordinators so as to develop an action-oriented monitoring system.

Area and Population

At the end of 2014, REACH was serving a total population of 49311 residing in 8344 households in 40 villages, located in the Medchal *mandal* in Ranga Reddy district , about 20-40 kms from Hyderabad in Telangana , in South India. The population is relatively evenly distributed between males and females, with a slight peak of females in the 20-24 year age group. The sex ratio (females per 1000 males) was favourable to females (1007) as compared to much lower figures observed for rural Ranga Reddy district (968), rural Andhra Pradesh (995) and rural India (947) (Census, 2011). About 25% of the population is below the age of 15 years, while another 67% are between the ages of 15 and 59 years as compared to 33% and 59%, respectively in rural Andhra Pradesh. The dependency ratio - the number of children below the age of 15 years and older persons aged 60 years and above per 100 persons in the working ages 15-59 years is 52 in Medchal as compared to 66 for the state of Andhra Pradesh reported for the census year 2001.

Antenatal Care (ANC)

The REACH focused on the well-being of pregnant women, as proper child development begins from the time of conception, which is in line with the plans of the state government. The Reproductive and Child Health (RCH) program of the government recommends that as part of antenatal care women receive two doses of Tetanus Toxoid injections, 90+ IFA tablets and at least three antenatal check-ups. Of the pregnant women, who had availed themselves of any ANC during the calendar year 2014, 99.41% had made three or more visits. The REACH's performance substantially exceeds the NFHS-3 reported national average of 52% of women receiving three or more ANC visits, which is considered a minimum for proper health of mother and child. The REACH database indicated that during the year 99% of the women had received 2 doses of TT and close to 99.7% had received 90+ tablets of iron and folic acid (IFA). However, there is no information on the actual number of IFA tablets consumed by these women.

Institutional Deliveries

Over the years, the number of institutional deliveries increased significantly and only 1.3% of women were delivered at their homes. While 37.3% had utilized MediCiti Institute of Medical Sciences (MIMS) hospital for delivery, 52.3% had used other private hospitals and only 9% of women had utilized government facilities for delivery. The infant mortality rate was found to be the lowest among the births occurred at the MIMS hospital.

Infant and Child Mortality

The REACH has succeeded in lowering infant and child mortality in Medchal mandal region as compared with Telangana state and the rest of India. The infant mortality and under-five mortality rates in the year 2014 were 31.3 and 2.9 per 1000 live births, respectively, for the Medchal *mandal*. The reported NFHS-3 figures per 1000 live births for India are 57 (IMR) and 74 (U5MR), whereas those for rural Andhra Pradesh are 64 (IMR) and 74 (U5MR), respectively. A break up of IMR according to age at death indicates that neonatal mortality accounted for 60% of the total infant deaths.

Birth Weight

Apart from infant mortality, birth weight is a key indicator of fetal development and mother/child health, as well as being a strong predictor of future well-being of the infant. The distribution of birth weights for REACH-covered children in 2014 revealed that low birth weight (LBW) was still a problem for concern. Using Blanc and Wardlaw formula, 14.6% of the infants had birth weights below 2.5 kg, similar to that reported for the year 2012 (14.6). It is well known that LBW is one of the important determinants of infant mortality particularly among the new born.

Childhood Immunization

Once children are born, REACH tracked every child from birth employing a team of nurses to give vaccinations to any children missed by the government health workers. Among children aged 12-23 months, 92.09% are fully immunized, 7.51% are partially immunized and the remaining 0.40 have not received any vaccinations. Coverage of BCG, Polio and DPT was higher than the percentage of children fully immunized. Almost all children (99.60%) had received BCG and 98.93% of children had received three doses of polio and DPT vaccine. Immunization against measles had been received by 92.63% of children.

Contraceptive Use and Fertility

Optimal child health often begins even before conception, with proper spacing between births, avoidance of early pregnancy, and limiting family size. As of 31st December 2014, 58.74% of eligible women in reproductive ages were protected against pregnancy by permanent methods of contraception, mostly female sterilization. The total fertility rate was 1.28, much below the replacement level of 2.1.

Thus the REACH experience indicates that health care activities can be strengthened through public-private partnership playing complementary role with that of the government.

SHARE (Science Health Allied Research & Education) India has been operating a health care programme – known as REACH (Rural Effective Affordable Comprehensive Health Care), an initiative to bring health care to the community with the help of trained village-based community health volunteers (CHVs), with particular focus on prenatal care for pregnant women, immunization of infants and family planning interventions.

The essential concept of REACH is that every mother and infant in the target area is tracked using a database from which, reports on women at risk of poor outcomes and in need of assistance, and information about children in need of vaccination can be generated so as to initiate prompt action. For this purpose, village level community health volunteers (CHVs) from the same community with a minimum of about eight years of schooling are chosen and trained to deliver simple health care services effectively by maintaining the antenatal, postnatal, and immunization records of the population as an electronic database. The main goal of the REACH project is to provide integrated maternal and child health, family welfare and primary health care services to the rural population involving the community to achieve a reduction in the morbidity, mortality and fertility levels.

GOALS

Initially, the emphasis was on:

- Reduction of fertility to below replacement-level (Total fertility rate(TFR) less than 2.1)
- Achievement of 100% childhood immunization by working closely with the medical and health authorities, Government of Telangana   .

These were later expanded to include:

- Prevention of blindness due to cataract.
- Elimination of anemia particularly in women in the reproductive age and young children.
- Reduction of infant mortality rate (IMR) to below 30 per 1000 live births.
- To study causes of IMR and adopt appropriate interventions.
- To develop an action-oriented monitoring system by developing a dynamic data base on all the pregnant women and infants and children in each household with the help of the CHVs, which is subsequently validated and updated by the Health Supervisors and Field Coordinators.

ACTIVITIES DURING 2014

The focus during the year was to improve the outreach of ANC and immunization activities in the villages of the project area through strengthening the procedures of updating and validation of household data, without disturbing the original aim of the project. For this purpose, initially a list of all the eligible couples for each village was prepared based on the REACH database. The two Field Coordinators and the four Health Supervisors visited each village as per a time schedule and contacted the households, updated and validated specifically the following information on women and children:

Women:

- Whether the woman was pregnant at the time of visit.
- If pregnant, data on ANC visits and TT doses.
- Pregnancy outcome including the type of delivery, place and date of delivery, and information on any fetal loss.
- In the case of non-pregnant married women, whether the women or their husbands had adopted any permanent fertility control methods.

Children

- Date of birth
- Immunization status
- Survival status of the children provided as per the existing data base.

Identification of New Households

- All new households which had come up since last year have been identified and information recorded.

Mother–Child Registers

During the year, the Health Supervisors also started maintaining an independent register for each of the villages and recorded all the information on all pregnant women and women who had delivered. This helped for undertaking cross-verification of details in the database, instead of visiting the villages every time. The present report covers activities and results for the calendar year 2014. It may be mentioned that the data may not be complete as some pregnant women who had gone to their mother's place for delivery may not have returned home and consequently the data may be incomplete. Generally, it would be better to allow at least 3 months more to get information on all the pregnancy outcomes that occurred during the calendar year.

AREA

The REACH project continued its activities in the 40 villages in the Medchal mandal (sub-district) of the Ranga Reddy district, about 40 kms from Hyderabad in Telangana , in South India. The details of the population and the villages in the REACH project area have been reported in the previous Annual Report for 2012.

POPULATION

At the end of 2014, REACH was serving a total population of 49311 (Males: 24470 and Females: 24841) residing in 8344 households in 40 villages, located in the Medchal mandal in Ranga Reddy district. The children under the age of 5 years formed 7.7% of the population, which is slightly lower than the figure observed in the year 2012 (8.7%). The population of elderly (60 years and above) was 7.58%. For the year 2012, the proportion of elderly was slightly different (7.4 %).

VITAL RATES

The Crude Birth Rate (CBR) (13.5/1000 population) was 2.3 points lower than that reported for 2012 (15.8/1000 population) and the Crude Death Rate (CDR) was 5.2/1000 population as against 6.2 for 2012, with a natural annual growth rate of -0 8 %, slightly lower than the rate of 1 % observed in 2012. The Infant Mortality Rate (IMR) was 31.3/1000 live births ,0.6 points lower than the rate of 31.9 reported for 2012 . The Under-five mortality rate (U5MR) was 2.9 per 1000 live births (40.9/1000 live births for the year 2012). The Total Fertility Rate (TFR) was 1.28, declined from 1.43 recorded in the previous year 2012.

SEX RATIO

The sex ratio (females per 1000 males) in 2011 was 1007 which is lower than the ratio observed in 2011 (1010). The sex ratio in the project area is favorable to females when viewed against the figures of 968 for rural Ranga Reddy district, 995 for rural Andhra Pradesh and 947 for rural India (Census of India, 2011). But in the case of children under five years of age, the sex ratio is higher (1078), suggesting a deficit of 40 female children per 1000 male children in the project area.

ANTENATAL CARE

In the recent past, the government has been emphasizing considerably on antenatal care and institutional deliveries. Under the National Rural Health Mission (NRHM) program, cash incentives are also offered to pregnant women, belonging to below-poverty line (BPL) families, to encourage institutional deliveries. Each pregnant woman should at least have a minimum of 3 visits (one in each trimester); but women are counseled to avail themselves of up to 9 visits (one per month). The distribution of pregnant women in REACH villages indicates that registering for ANC during the first trimester is 40.3, 36.2 percentage points higher than the figure of 4.1% observed in the previous year. In an ideal condition when all pregnancies are reported, the number of pregnant women in each

trimester is expected to be the same. One of the reasons for the observed low percentage of pregnancies in the first trimester may be that woman informs her pregnancy status only after her pregnancy is confirmed. It is necessary to identify all pregnancies early in the first trimester in order to initiate providing antenatal care services early to all pregnant women.

In the REACH project area, 99.41% of the women who had delivered during the year had 3 or more ANC visits, which is similar to the performance achieved in 2011 (93.6%). Almost all pregnant women reported to have received iron and folic acid (IFA) tablets and 99% had received 2 doses of Tetanus Toxoid (TT) vaccination.

PREGNANCY OUTCOME

The analysis of pregnancy outcome included abortions, still births and deliveries either normal or caesarian. There were a total of 712 pregnant women who had their pregnancy outcome during the year 2014 (Table 1).

Table 1: Pregnancy outcomes in REACH, 2011 and 2014

Year	No of pregnant women	Abortions(%)	Still births(%)	Deliveries	
				Normal (%)	Caesarian(%)
2011	1005	8.8	2.4	48.2	40.7
2014	712	5.0	1.4	42.9	50.7

The incidence of reported abortions was 5.0% during the year 2014. It should be recognized that early abortions might not have been noticed/ reported by the women. Forty three percent of deliveries during the year 2014 were normal deliveries, while 50.7% were delivered by caesarian section. A comparison of pregnancy outcome for the year 2011 and 2014 indicates that the incidence of abortion was lower in 2014 as compared to the previous year (7.8% against 8.8%). Similarly, the incidence of still births was lower in 2014 (1.4%) as compared to 2.4% in 2011. Thus, the pregnancy loss (abortions + still births) was 6.4% in 2014, lower than the figure observed in 2011 (11.2%).

Figure 1: Distribution of pregnancy outcome, 2012 and 2014
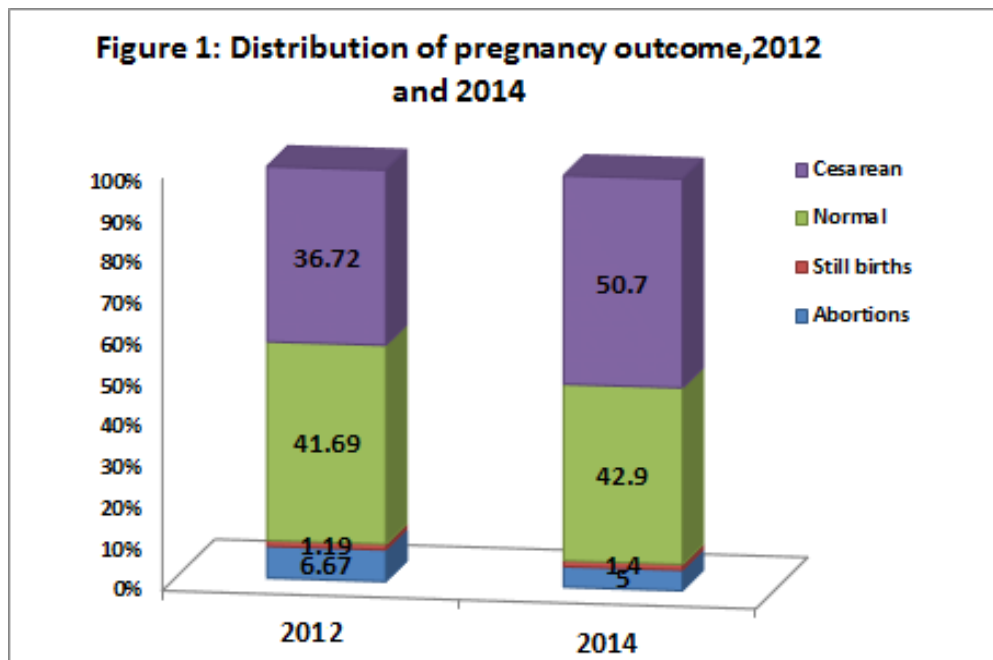
Extent of Caesarian Deliveries: The distribution of deliveries according to the type of and place of delivery for the year 2014 is presented in Figure 2. As compared to 37.70% caesarean section deliveries taking place in the government health facilities, a much higher proportion of caesarean deliveries are conducted in the private hospitals (50.79% in MIMS hospital and 60.73% in other private

hospitals). The lower proportion of caesarian section deliveries in government facilities may be due to the fact that in all the government hospitals in the rural areas, facilities for caesarian operations may not be available.

Figure2: Distribution of deliveries according to type and place of delivery ,2014
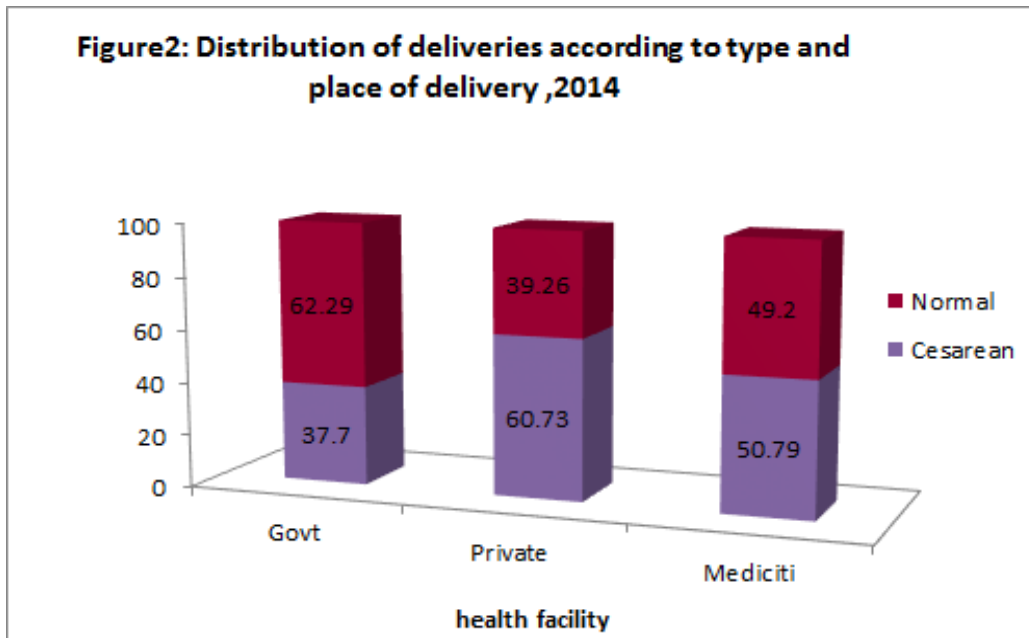
It is surprising to note such a high proportion of caesarian section deliveries is taking place in the rural areas of REACH. It would be of interest to identify the possible reasons for the occurrence of high proportion of caesarian deliveries in the study population and more importantly to find out how many women who had caesarian section had underwent regular antenatal check-ups.

Institutional Deliveries

As reported in the previous annual report for 2012, the share of the institutional deliveries has continue to increase since 2000. As a result, the number of home deliveries has declined significantly over time. In 2014   there were only 1.3 % home deliveries. There has also been a major shift of deliveries at governmental health facilities and home to private hospitals including MIMS hospital. There has been a continuous increase in the proportion of deliveries at MIMS hospital, increasing from 16-18% between 2000-2006 to 33% in 2007 and further to 37% in 2014 (Figure 3).

Figure3: Trends in percentage of deliveries according to place of delivery,2000-2014
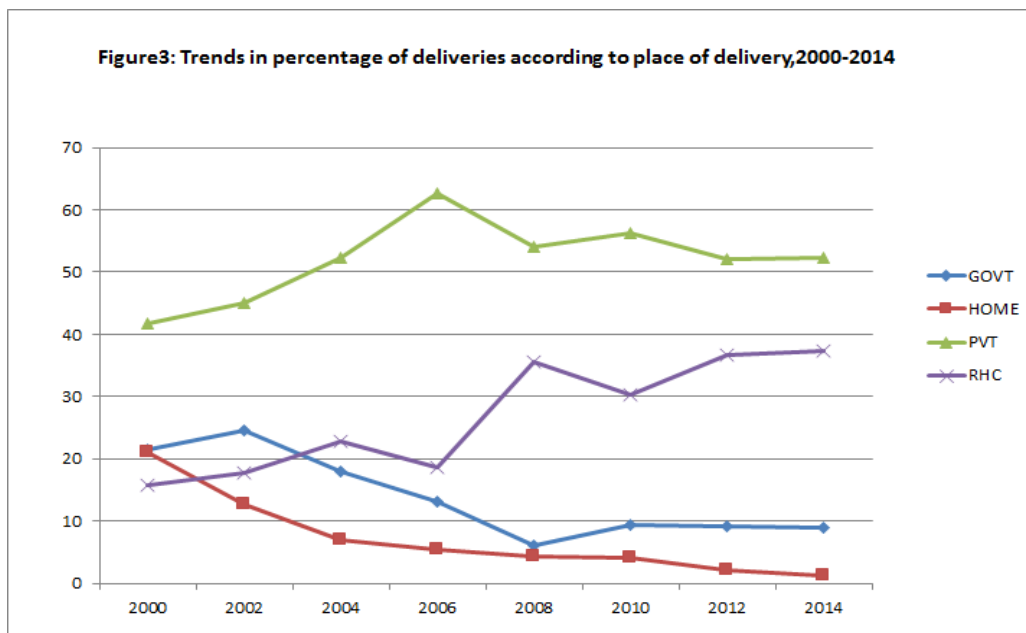
PREMATURITY

The prematurity rate (born before completing 37 weeks of gestation), as reported by the women and verified as far as possible, wherever discharge information was available, was 0.1%, which is much lower than the rate reported in 2012 (0.3%).

BIRTH WEIGHTS

Birth weights were available for 665 infants born during 2014. The distribution of the birth weights is presented in Figure 4. Using Blanc and Wardlaw formula (sum of number ≤2.4 kg + 25% of the number in the 2.5 kg group expressed as % of total birth weights),14.77% of the infants had birth weights below 2.5 kg., very similar to that reported for the year 2012 (14.88%)Use of digital scale with 10 g accuracy would provide a better estimate of the prevalence of low birth weight babies in the study area.

Figure 4: Cumulative percentage distribution of birth weights in 2014
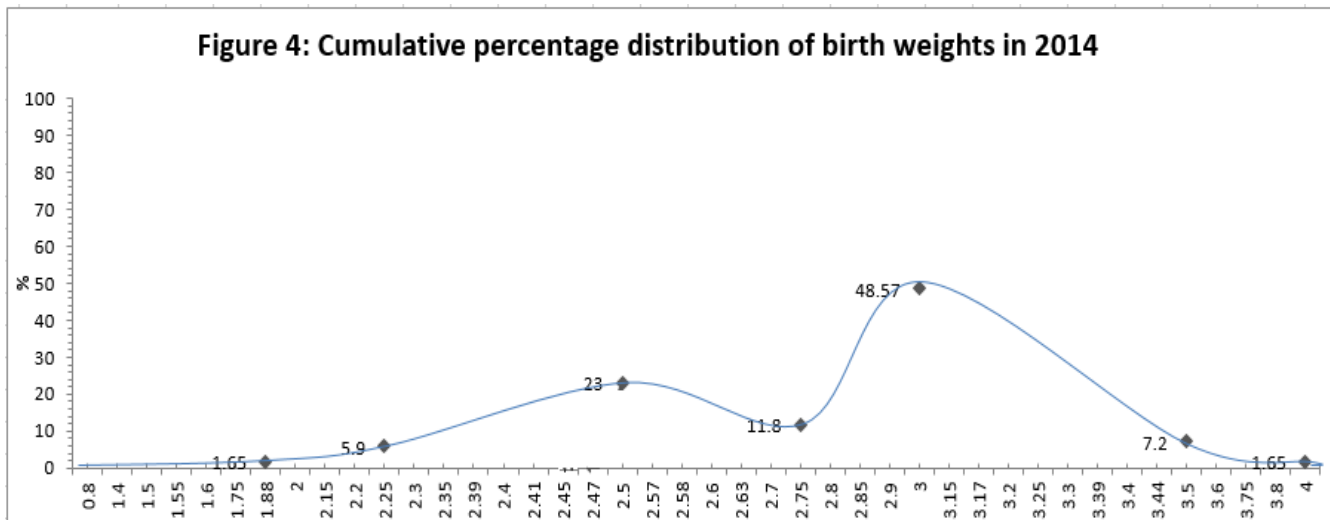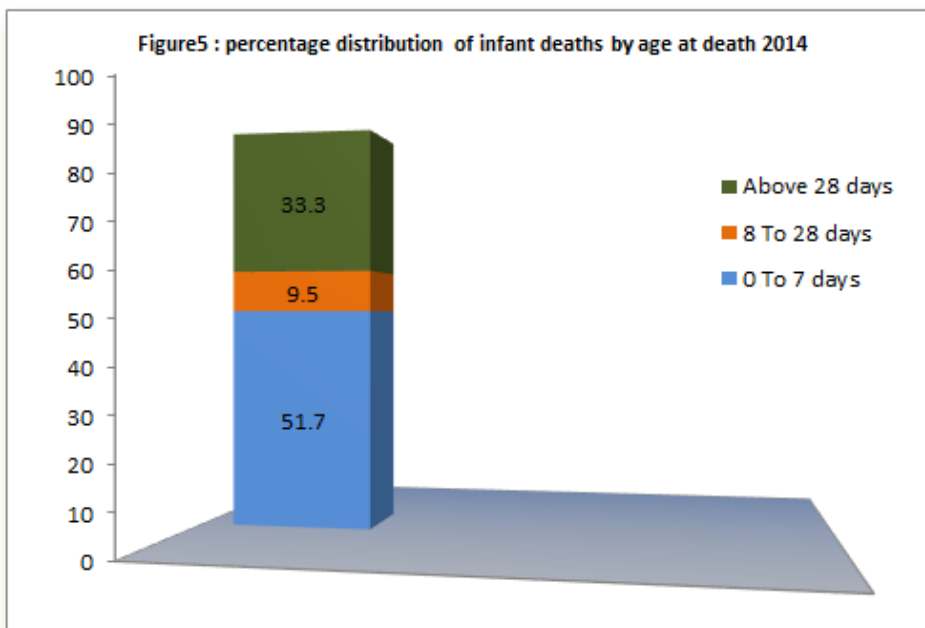
Infant Mortality Rate

The infant mortality rate (mortality under 12 months of age) and under 5 years mortality rate (U5MR) are 31.3 and 2.9 per 1000 live births in 2014 as compared to 57 and 74 for the country as a whole and 64 and 74 for rural Andhra Pradesh for the year 2005-06 based on NFHS-3, all of which are much higher. Although these trends are encouraging still a lot needs to be done to accelerate reduction in infant mortality in the project area.

Neonatal Mortality

Neonatal mortality rate (NNMR) still remains high despite the fact that almost all deliveries are institutional (98.7%). The proportion of infant deaths taking place in the project area within the first four weeks of life is as high as 66%, with 34% occurring within the first week. In the previous year 2012, neonatal deaths accounted for over three-fourths of infant deaths. It is encouraging to note that this figure has come down to about 60% in 2014. However, there is an immediate need to focus on this component to bring about a significant reduction in infant mortality rate in the area. This might require close monitoring of all the deaths occurring during the first week of life by trained health workers.

Figure5 : percentage distribution of infant deaths by age at death 2014

- Above 28 days: 33.3
- 8 To 28 days: 9.5
- 0 To 7 days: 51.7

CHILD IMMUNIZATION

REACH attempts to ensure that all the children born in the area will remain healthy and thrive. To ensure universal immunization, REACH functionaries tracked every child from birth and vaccinated any child missed by the government health functionaries. Children in the age span 12-23 months who received BCG, three doses each of DPT and OPV (excluding OPV '0') and measles are considered to be fully immunized.. The full immunization coverage was 92.09%. Measles immunization was 92.63% as against 91.44% in 2012 The full immunization coverage in REACH villages is more than double the all-India average of 44% and state figure of 46% from NFHS-3..

Contraceptive Prevalence and Fertility Decline

Optimal child health should begin even before conception, with proper spacing between births, avoidance of early pregnancy, and limiting family size. At present, the primary role of REACH in this process is to inform women of their options for permanent sterilization once they have borne their desired number of children, and to refer them to a nearby health facility for the surgery. However, REACH's efforts to improve child survival also have a bearing on family planning, since couples are less likely to desire large families if they can be more certain that all their children are more likely to survive to adulthood. Of the total of 10307 eligible women (15-49 years) in Medchal Mandal, 61.7% were sterilized. Contraceptive prevalence by sterilization increases sharply from 10.61% for women with one living child to 85.3% for women with 3 living children and further to 86% for women with 4 or more living children. About three-fourths of women with 2 living children were sterilized. Because of the growing number of women accepting sterilization at younger ages and lower parities, the fertility impact of contraception has been quite significant in the study area.

One way to assess the fertility impact of contraceptive prevalence is to compute age- specific fertility rates (ASFRs) and total fertility rate (TFR). The TFR, a summary measure that is calculated as five times the sum of ASFRs, is interpreted as the number of children a woman would bear during her reproductive years if she were to experience the age-specific fertility rates prevailing during the given year.

Fertility in Medchal region has continued to decline to below replacement-level. A TFR of 1.28 children per woman is estimated for the year 2014 (Table 2). The age-specific fertility rates follow the expected bell-shaped pattern. The peak fertility is observed in the 20-24 years age group. Fertility rates decline sharply after age 25, reaching extremely low levels for women age 35-39 and 40-44 years (Figure 2). Current fertility is characterized by a substantial amount of early childbearing: 66.79% of total fertility is accounted for births in the age group 15-24, and the contribution of women

age 35 years and above to total fertility is 1.2%.

Table 2: Age-specific fertility rates and total fertility rate,2014

Age group	Women	Births	Age specific fertility rates
15-19	2200	32	0.0145
20-24	2673	421	0.1575
25-29	2686	179	0.0666
30-34	2243	30	0.0133
35-39	1712	7	0.0040
40-44	1684	1	0.0005
45-49	1396	0	0
Total	14594	670	0.2564

Total Fertility Rate (TFR) = 0.2564 X 5 = 1.28

Figure 6: Age specific fertility rates (ASFRs), 2014
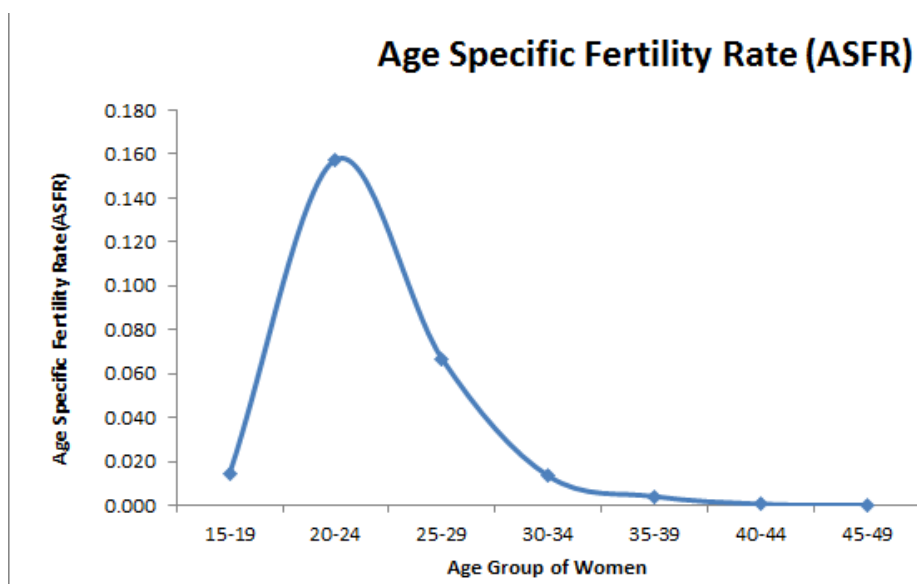
CONCLUSION

REACH has progressed in the recent years from a marginal database to a proven tool for public health. Thus it is clear that, community health care services can be substantially strengthened through public private partnership by playing complementary role in extending the services and utilizing action based health metrics to monitor and identify the areas of non-performance basically to promote health action. Such an exercise is also useful to provide data on fertility patterns, mortality among infants and children on a continuous basis.

In order to achieve a more complete dynamic database, changes taking place in the demographic profile of the village need to be updated regularly. For this purpose, we have embarked on a project to completely map the houses in the villages of our target *mandal* using Google Earth and GPS information systems (GIS). The project is now in its third year, and all 40 villages in Medchal mandal have been mapped. (Including updates to villages that have changed since initial mapping). The mapping of the houses is now extended to the adjacent Shamirpet mandal with a population of about 100000. As we

have linked this software to our database, the process of surveying families in Medchal mandal can be done significantly faster now.

PUBLICATION

Tatineni, A. Vijayaraghavan, K., Reddy, P.S., Narendranath, B. and Reddy, R.P., "Health Metrics Improve Childhood Immunisation Coverage In A Rural Population Of Andhra Pradesh *Indian Journal of Public Health,* 2009, <u>53</u>:41;43

Appendix – Details of the REACH Program

REACH (Rural Effective Affordable Comprehensive Health Care) is focused around two core hypotheses:

1. Effective rural public health measures cannot be delivered with full penetration unless there is a reliable way to track which individual has received which interventions.
2. Village level workers with relatively low-education can achieve excellent results, if they are provided with the data they need to do their jobs.

The essential concept of REACH is that every mother and infant in the target area is entered into and tracked by a database. From this database, reports can be generated that show which women are in need of assistance with antenatal care, which children are in need of vaccination or at risk of poor outcomes, and how the population is faring by commonly-used health indicators. However, the second critical component is the infrastructure by which this database is created and maintained, and through which its information becomes action.

The organization structure chart given below indicates different categories of staff who are involved in data collection, scrutiny, data entry and also monitoring the project activities.
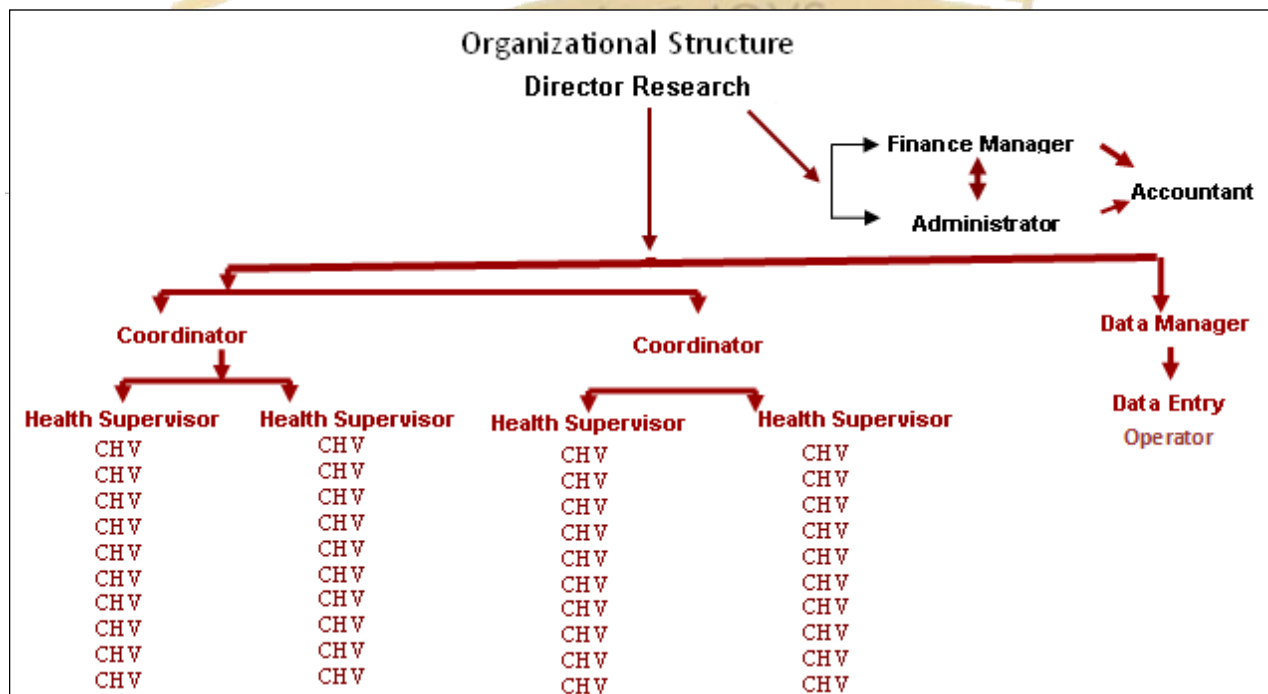
The REACH project pays and supervises a corps of community health volunteers (CHVs), one per covered village. (Although called "volunteers", each is paid an honorarium of Rs 500 per month, plus Rs 100 for attending weekly meeting and an incentive of Rs 100 for reporting key events such as child deaths). The CHVs are responsible for information-gathering in their villages as well as assisting with intervention on identified problems. Each CHV is expected to visit five households in her village each day, thus covering about 30 in the span of a working week. During these visits, she inquires about immunizations received, new pregnancies, deliveries, and illnesses. Every week, she is expected to travel to the SHARE central research office and present the registry book in which she keeps a record of all mothers and children in the village.

Each CHV reports to one of four Health Supervisors, who in turn report to one of two REACH Coordinators. During the weekly CHV meeting, each CHV reviews her register with the concerned Supervisor and Coordinator. Both the Supervisor and Coordinator copy new data out of the register onto data entry forms that do not leave the SHARE office. In this way, we maintain a local copy of the data at all times. More importantly, through this process of multiple people reading and copying the data, it becomes easier to notice items that have been accidentally missed. Once data have been copied, the entry forms are given to eight data entry technicians, who upload it in a standardized format into our central database. The REACH database itself is a database, with a custom-designed Visual Basic front end that provides the data entry, reporting, and query functionality. Compact copies of the database can also be exported into a single-file format for offline work.

Once a problem is identified through the database reports or during the weekly CHV meetings, the REACH field staff rectifies the errors, if any. We maintain our own supply of vaccines and staff of Auxiliary Nurse Midwives (ANMs) who are able to administer them. Each CHV is aware of the days when REACH staff will be coming to her village, and through the review of the database reports, is also aware of which children require immunizations. Every day, a REACH field team visits roughly three villages to vaccinate missed children and also to follow up on any missing data identified by the prior week's CHV meeting. Similarly, when a woman is not receiving antenatal care, the CHVs are expected to act as our "eyes and ears". They are able to encourage pregnant women to seek care, and also to report back if there is a problem preventing ANC from happening.

As noted above, this system of a parallel (complementary) vaccination network alongside the government machinery is remarkably effective, but also costly. We are in effect duplicating work that the Government is theoretically paying their workers to do already. The REACH field team and CHV corps can be maintained in Medchal *mandal* through the generosity of SHARE's sponsors, but it would be tremendously wasteful to replicate this model at the state or national level. Thus, our next step will be to demonstrate that REACH can be effective even in the absence of a parallel CHV network, i.e. by providing information directly to government health workers.

S.No	REACH FACT SHEET	
	Area & Households (As on Date)	Dec-2014
1.	Area in Sq. km	178
2.	No. of Villages	40
3.	Grama Panchayats	18
4.	No.of Revenue Villages	29
5.	No. of Households	8,344
Population (Number As on Date)		
6.	Males	24470
7.	Females	24841
8.	Infants (<12 Months) Males	299
9.	Infants (<12 Months) Females	319
10.	Children(1-4 Years) Males	1676
11.	Children (1-4 Years) Females	1539
12.	Children (0-4 Years) Males	1975
13.	Children (0-4 Years) Females	1858
14.	Women in reproductive age (15-49 years)	14594
15.	Elderly(≥60years) Males	1504
16.	Elderly(≥60years) Females	1898
Births and Deaths (From January 1 – end of the month under report)		
17.	Live Births Males *	322
18.	Live Births Females *	348
19.	No of Twins	4(F=6,M=2)
20.	No. of Still births	10
21.	Deaths(<12 Months) Males	11
22.	Deaths(<12 Months) Females	10
23.	Deaths(1-4 Years) Males	1
24.	Deaths(1-4 Years) Females	1
25.	Deaths (all ages) Males	149
26.	Deaths(all ages) Females	110
Currently Pregnant Women (As on Date)		
27.	No.of currently pregnant women	307
28.	No. of currently pregnant women in 1st Trimester	124
29.	No. of currently pregnant women in 2nd Trimester	162
30.	No. of currently pregnant women in 3rd Trimester	21
Deliveries & ANC Services availed (From January 1 – end of the month under report)		
31.	No.of deliveries **	676
32.	No. of Abortions	36
33.	Percentage of women with 3+ ANC visits	99.41
34.	Percentage of women received 2 TT	99
35.	Percentage of women received IFA for 90+ days	99.7
36.	Percentage of Institutional Births	98.7
37.	Percentage of deliveries at MediCiti	37.3
38.	No.of maternal deaths	0
Family Planning (As on Date)		
39.	No.of Eligible couples(15-49)	10,307
40.	No.of sterilized Couples	6,364
41.	Percentage of women sterilized	61.6
42.	0 Living Children	1.57
43.	1 Living Child	10.61
44.	2 Living Children	75
45.	3 Living Children	85.3
46.	4+ Living Children	86
47.	2+ Living Children	79.8
48.	No.of women who had undergone hysterectomy	367
49.	Percentage of men sterilized	0.12

Child Immunization(age 12-23 months) (As on date)		
50.	Percentage received BCG	99.60
51.	Percentage received 3 doses of DPT	98.93
52.	Percentage received 3 doses of OPV	98.93
53.	Percentage received Measles	92.63
54.	Percentage received All(Fully immunized)	92.09
55.	Percentage received partial(Partially immunized)	7.51
56.	Percentage received None	0.40

Indicator	Row Discription	S.No
*	Including Twins	17,18
**	Including Still births	31
M,F	Males , Females	19