Project Proposal seeking Financial Assistance for Establishing of Nursing School-College, Vocational Training Centre, 30 Bedded Hospital & Full Fledged Mobile Medical Van for the Development of Targeted People of Khunta Block in the District of Mayurbhanj, Odisha

Submitted to:

The Joint General Secretary
National Committee for Promotion of Social and Economic Welfare
Department of Revenue, Ministry of Finance
Government of India
New Delhi

Submitted by:

SIKHYA-O-SIKHYA (SOS)

Plot No. 18/A, B.J.B. Nagar, Bhubaneswar- 751 014
Dist- Khurda, Odisha, India.
Phone : 0674-2310659/2434449/2436311, Mobile : 9437484398
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To

The Joint General Secretary
National Committee for Promotion of Social and Economic Welfare
Department of Revenue, Ministry of Finance
Government of India,
New Delhi

Sub: Application Under Section 35 AC of Income Tax Act, 1961 and Rules of 11 F to 11 Income Tax Rules, 1962 Before the National Committee for Promotion of Social and Economic Welfare, Department of Revenue, Ministry of Finance, Government of India, New Delhi-110 001.

Respected Madam/Sir,

I am submitting herewith the application duly filled in along with all necessary required documents for sanction of the project to be established at Khunta Block in the District of Mayurbhanj, Odisha.

With regards,

Yours faithfully,

(Amiya Kumar Mohanty)
Secretary

Copy to the Section Officer (National Committee), Ministry of Finance, Department of Revenue, Govt. of India, New Delhi for necessary action.

CHECKLIST

1.	Application in Prescribed Form, with Signatures of Management Body and seal of the Organization;
	Yes, - as Annexure-I
2(a).	Copy of registration certificate.
	- As Annexure-II
(b).	Trust Deed/Certification of incorporation of company;
	- As Annexure-III
3.	Copy of Resolution passed by the Executive Body of Society/Company to undertake the work u/s 35AC of the Income Tax Act 1961;
	-As Annexure IV;
4 (a).	complete addresses of the applicant organization and its Society/promoters along with e-mail addresses and telephone numbers, wherever possible;
	-As Annexure V;
(b).	Brief note on past activities & Credentials of Society/Promoters, with details of experience in activities similar to the object of the proposed project;
	-As Annexure VI;
5(a).	Project Report, in a focused manner, in brief, highlighting activities proposed to be undertaken;
	-As Annexure VII;
(b).	Location of project (State district and Taluka) date of commencement and completion;
	-As Annexure VIII;
(c).	Geographical coverage of the project, Area to be covered by Medical / other camps etc., if any, and Population coverage;
	-As Annexure IX;
d).	Whether Rural/Urban/Semi urban;
	Rural, Semi Urban
(e).	Estimated cost of the Project (with break up);
	-As Annexure X;
(f)	Detailed break-up of recurring and non-recurring expenditure on the project (with break up);
	-As Annexure XI;

(g) Blue prints along with professional cost estimates in support of construction activities if any;

Not Applicable;

(h) What percentage of the total cost is attributable towards infrastructure or asset building?

Zero- 20 %;

(i) Expenditure incurred as on date on the proposed project;

(j). Funding pattern of the proposed project and extent of Government grants/ foreign aids likely to be available for the proposed project in next 3 years;

The Organization has NOT applied for any grant or assistance from any other agencies including foreign aids except applying under 35 AC of the Income Tax Act, 1961; However there shall be 10% contribution by the organization to be supported out of contributions and donations.

6. Information regarding availability of land/necessary infrastructure to execute the project/land, documents to be enclosed;

Annexure – XII-B

7(a) Clear identification and description of target group proposed to be benefited from the project with details in appropriately measurable terms;

State	**:** Odisha
District	**:** Mayurbhanj
Block	**:** 26
No. of Gram Panchayats	**:** 382
No. of Villages	**:** 3940
No. of Households	**:** 472123
Total Population	: 2223456
ST Population%	**:** 56.60
SC Population%	**:** 7.68

(b). Social and economic profile of target population;

Population of Mayurbhanj (As per 2001 Census)

		Persons	**Rural**	**Urban**
Total	:	2223456	2067756	155700
Male	:	1123200	1041057	82143
Female	:	1100256	1026699	73557
SC (Schedule Caste) – Total	:	170835	154440	16395
SC (Schedule Caste) – Male	:	85844	77436	8408
SC (Schedule Caste) – Female	:	84991	77004	7987
ST (Schedule Tribe) – Total	:	1258459	1230583	27876
ST (Schedule Tribe) – Male	:	631149	616673	14476
ST (Schedule Tribe) – Female	:	627310	613910	13400

I.	Quantification of per capita or per unit cost of the activity/event keeping the target group into Account;

BPL, SC/ST/OBC, Minority community, handicapped, and needy people residing in rural areas Mayurbhanj District so that there is a big need to intervention for them.

The proposed project will cater to the health technical education & health needs of the Below Poverty Line, Minority community and needy patient residing in rural, slums, industrial, unauthorized Basti, in Mayurbhanj District and as a result the per capita cost of the activity is far below the total expected cost of the project.

8(a)	Income criteria for selection of service to beneficiaries belonging to poor/weaker section of the Society;

The Government of India's regulations and bench marks in determining economically poor and socially marginalized people will be applied in determining the beneficiaries' status in terms of extending the benefits to them. People living under Below Poverty Line, Reserved Category, Minority community.

The Executive Committee Members of the Sikhya-O-Sikhya resolved to provide 100% free ship /reservation to those beneficiaries of the project who belonged to the weaker sections, earning Rs.18000/- p.a. or less and whose number will at least be 50% of the total beneficiaries of the project.

8 (b)	Normal and subsidized fees pattern adopted by the Institute/ Society;

No fee will be taken from the beneficiaries of the project.

8I	Concession in fees etc. for training of poor/weaker section and assistance / equipments provided to the beneficiaries for income generation activity;

Not Applicable.

8 (d)	Cost benefit analysis;

Technical project will be a life time project and thousands of poor and needy shall be benefitted and shall be employed in different Govt. Hospital, Private Nursing Home as well as self employed. Health project will be a life time and Thousands of poor and needy students will be benefitted each year till the Nursing school- college function. We are also planned to create corpus fund to run the project after funding period. So that we can say that input cost will be much smaller than the outcome/achievements of the project

After completion of the education one youth shall be able to earn a minimum of Rs.20000/- per month.

9.	With regard to free ship/reservation available to beneficiaries belonging to economically weaker sections of the Organization the following resolution may be furnished if your institution/Trust is agreeable to the condition that "The Board of Organization unanimously resolved to provide 100% free ship/

reservation to those beneficiaries of the project who belonged to the weaker sections of the Organization earning Rs. 18,000/-p.a. or less and whose number will at least be 50% of the total beneficiaries of the project";

-As Annexure XIII

10. Information regarding recognition of school/vocational training centre/Laboratory Technician training Centre etc. from the concerned Education/Technical Board;

-Not Applicable

11. Details of similar activities undertaken by the applicant organization in the past and the achievements/accomplishments. Wherever possible, the quantifications of work/activities undertaken should be mentioned in appropriately measurable terms of past activities, with copies of Annual / Activity Reports of last 3 years;

-As Annexure XIV

12. How will the continuance of proposed project be ensured and how would the assets created maintained subsequent to the end of the period of the Project;

The assistance sought from the Government is of one time in nature and the project will be sustained on its own through community contributions, donations and voluntary contributions from beneficiaries. The Society will also build resources so that the project will be continued and sustained on its own.

13. Audited Accounts for the last three years;

-As Annexure XV

14. Status Report for the projects approved earlier by NC, if any, with separate audited accounts of the project u/s 35AC;

Applying First Time

15. Approval u/s 12A & 80G of the IT Act, if any;

Yes, - As Annexure XVI

16. Approval under FCRA, if any;

Yes,- As Annexure XVII

17. Please specify the clause of Rule 11 of IT Rules 1962 under which the proposed project would qualify for approval;

11K (i) of IT Rules, 1962

18. English version of documents, which are in regional language.

All documents are in English

Yours sincerely,

(Amiya Kumar Mohanty)
Secretary

As Annexure-I

1. Application in Prescribed Form, with Signatures of Managing Organization and seal of the Organization;

(To be filled in duplicate for each project in Hindi or English)

Application Under Section 35AC Of Income-Tex Act, 1961 and Rules 11F to 11N of the Income-Tax Rules, 1962 before the National Committee for Promotion of Social and Economic Welfare, Department of Revenue, North Block, New Delhi- 110 001

1.	**Name of the Applicant Organization**	**:**	**SIKHYA-O-SIKHYA (SOS)**
2.	**Address and Phone Numbers**	**:**	Plot No. 18/A, Sarat Bhawan, B.J.B. Nagar, Bhubaneswar- 751 014, Odisha, Phone : 0674-2310659
3.	**Applicant is a:**		
	a) Public Sector company b) Company other than (a) above c) Local Authority d) Association constituted as a **a)** Registered Trust b) Public Charitable Trust **c) Registered under Section** d) 25 of Companies Act,1956 e) Else please specify what:	**:**	Registered under the Societies Registration Act – XXI of 1860. **Registration No: KRD5716-755/93-94, dated 01/03/1994 and Re-registered under IGR Odisha** **No. 22849/59 of 2008-2009** **Date of Registration: 01/03/1994** **Date of Re-Registration : 17/07/2008** Copy of the Registration Certificate enclosed in **Annexure- II**
4.	**Is the applicant assessed to Income Tax? If so, please give particulars of:**	**:**	
	(a) Permanent Account Number/GIR No:	**:**	**PAN No. AABAS3434Q**
	(b) Designation and address of the Assessing Officer:	**:**	**Office of the Income Tax Asst. Commissioner of Income Tax,**
	Latest year for which a return of tax has been filed:	**:**	
5.	**(a) Does the applicant maintain regular accounts?**	**:**	Yes
	(b) Years for which copies of audited accounts have been annexed:	**:**	Audited statements of accounts are available for the last three financial years.
	Year ending	**:**	**Name of the Auditor**
	(i) 2012-2013	**:**	M/s. R. K. Sahoo & Co.
	(ii) 2011-2012	**:**	-do-

	(iii) 2010-2011	:	-do-
6.	**In case the applicant is an Association of Institution:**	:	**Society Registration Act 1860.**
(a)	Certified copies of following documents have been enclosed with this application:	:	
	(i) Registration Certificate;	:	Enclosed
	(ii) Memorandum of association & By Laws;	:	Enclosed
	(iii) Annual Report of last 3 years;	:	Enclosed
	(iv) Organizational Review report of last 5 years;	:	
	(v) FCRA certificate issued by Ministry of Home Affairs, Govt. of India;	:	Enclosed
	(vi) Annual Audit Report of last 3 years;	:	Enclosed
	(vii) Income Tax return of last 3 years;	:	
(b)	Particulars of approval under Section 10(23C)/80-G of the Income–tax Act, 1961, if any:	:	Applied, under Consideration with Income Tax

(c)	**Names, addresses and designation of person(s) managing the organization:**		
Sl. No.	**Name**	**Address**	**Designation**
01.	Prasanna Kumar Pradhan	Plot No. 8-A, Ashok Nagar, Bhubaneswar- 751 009, Odisha	Chairman
02.	Nirmal Kumar Rath	AMITY BUSINESS SCHOOL, HIG-15, Gangadhar Meher Marg, Jaydev Vihar, Bhubaneswar- 751 013, Odisha	Vice-Chairman
03.	Abhaya Kumar Samantray	Plot No. 309/1801, Sub-Plot 1, SBI Campus, Sailashree Vihar, Bhubaneswar- 751 021, Odisha	Joint Secretary
04.	Deepak Kumar Pattanaik	Flat No. 2, Sai Kanti Apartment, Laxmisagar, Upara Sahi, Bhubaneswar- 751006, Odisha	Treasurer
05.	Jagadish Kumar Pattanaik	Plot No.2, Ratnakar Bag-I, Tankapani Road, Bhubaneswar- 751 018, Odisha	Member
06.	Rabindra Kumar Khuntia	Qtr. No. 2RA-9/1, Kalpana Flat, B.J.B. Nagar, Bhubaneswar- 751 014, Odisha	Member
07.	Amiya Kumar Mohanty	Plot No. 18/A, 1st Floor, B.J.B. Nagar, Bhubaneswar- 751014, Odisha	Secretary

(d)	What have been its activities during the past three years/the track record	:	Copy enclosed
(e)	What has been the source of funding of the past activities of the organization? Also indicate source of funding for the present project?	:	Copy Enclosed **in Annexure –** Jan Shikshan Sansthan, Sponsored by Ministry of Human Resource Development, Govt. of India.
(f)	The activities are for the benefit of:	:	Rural Poor and BPL students & BPL people of the communities.
(g)	Is there any provision in the constitution, rules, regulation etc. under which the income or corpus of the organization can be put to use for a non-charitable purpose?	:	No
7	**Particulars of the Project or Scheme**	:	
a.	**Title**	:	**Establishment of Nursing School-College, 30 Bedded Hospital & Full Fledged Mobile Medical Van and Vocational Training Centre for the Socio-Economic and Health Development of poor people of the Khunta Block of Baripada, Mayurbhanj District.**
b.	Date of commencement	:	
c.	Duration and likely date of completion	:	
d.	Estimated cost	:	Rs.12,51,24,087.00
e.	Persons likely to benefit from it	:	Socio-economic weaker, BPL& marginalized person will be directly benefited through this project.
f.	Would project benefit flow to the manager, trustees etc, other than employees of the institution:	:	No.
g.	How is the applicant equipped with the man-power, expertise, infrastructure etc. to execute the project?	:	Applicant will provide expertise man power to execute the project.

8. In case the applicant is a company:

(a) Is it bound to undertake the project or scheme applied for under any law or as a result of any agreement with its employees?

(b) In case any capital asset is to come into existence under the project or scheme, what arrangements have been made to divest the company of the ownership of such assets?

9. (a) Has the applicant been panelist under the Income-tax Act for concealment of income during the three assessment years immediately preceding the date of application and if yes, the details thereof?

No

(b) Has any of its present trustees, principal officers etc. been convicted of any offence during the last three financial years and if yes, the details thereof?

No

10. Please give particulars of earlier projects or schemes of the organization, which have been considered by the National Committee and specify the details of acceptance or rejection.

11. (a) The Applicant verifies that the particulars in this application and its annexure are correct.

(b) The National Committee for Promotion of Social and Economic Welfare will be informed six monthly of the amount of contribution raised, the total amount spent and the progress/ achievements made in respect of the project or scheme approved by it; and

(c) Audited Annual Accounts along with the Audit Report will be furnished.

Date :

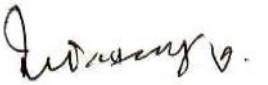
Place : Baripada

(Amiya Kumar Mohanty)
Secretary

As Annexure- IV

Annexure from the original resolution of the Executive Committee meeting held on dated 26th April, 2013 at Office of **Sikhya-O-Sikhya, Baripada.**

It was unanimously resolved that **Sikhya-O-Sikhya** will submit project proposal for seeking financial assistance for Nursing School-College, 30 Bedded Hospital, Patholab & Full Fledged Mobile Medical Van for the development of the targeted people of Mayurbhanj District from the National Committee for Promotion of Social and Economic Welfare under the provisions of 35 AC of Income Tax Act, 1961 of Government of India.

Names, Designation & Signatures of person(s) managing the organization :			
Sl. No.	**Name & Address**	**Designation**	**Signature**
1.	Prasanna Kumar Pradhan	Chairman	
2.	Nirmal Kumar Rath	Vice-Chairman	
3.	Abhaya Kumar Samantray	Joint Secretary	
4.	Deepak Kumar Pattanaik	Treasurer	
5.	Prof. Jagadish Kumar Pattanaik	Member	
6.	Rabindra Kumar Khuntia	Member	
7.	Amiya Kumar Mohanty	Secretary	

Date :

Place :

(Amiya Kumar Mohanty)
Secretary

As Annexure- V

LIST OF SOCIETY / PROMOTER

List of Executive Body Members

Sl No	Name	Address	Telephone	E-Mail
1.	Prasanna Kumar Pradhan	Plot No. 8-A, Ashok Nagar, Bhubaneswar- 751 009	0674-2534233 9937152145	Pradhanprasanna1@gmail.com
2.	Nirmal Kumar Rath	Amity Business School, HIG-15, Gangadhar Meher Marg, Jaydev Vihar, Bhubaneswar- 751 013.	9861160029	nirmalkumarrath@gmail.com
3.	Abhaya Kumar Samantray	Plot No. 309/1801, Sub-Plot 1, SBI Campus, Sailashree Vihar, Bhubaneswar- 751 021.	0674-2721393 9861022180	ask_bbsrvihar@yahoo.co.in
4.	Deepak Kumar Pattanaik	Flat No. 2, Sai Kanti Apartment, Laxmisagar, Upara Sahi, Bhubaneswar-751006, Odisha	9861122756	Deepupatnaik1955@yahoo.in.com
5.	Jagadish Kumar Pattanaik	Plot No.2, Ratnakar Bag-I, Tankapani Road, Bhubaneswar- 751 018.	0674-2431580 9437171469	Jagdish.pattnayak@gmail.com
6.	Rabindra Kumar Khuntia	Qtr. No. 2RA-9/1, Kalpana Flat, B.J.B. Nagar, Bhubaneswar- 751 014.	0674-2310248 8895348628	rkk_2000@gmail.com
7.	Amiya Kumar Mohanty	Plot No. 18/A, 1st Floor, B.J.B. Nagar, Bhubaneswar- 751014, Odisha	0674-2310659 9437484398 9437184398	amiyamohanty_18@yahoo.co.in

As Annexure- VI

Brief Note on Past Activities & Credential of the Society

(for last 5 yrs.)

ATTACHED

Mission of the Organization :

The mission of Sikhya-O-Sikhya is to work for the socially deprived sections and the people who actually require professional assistance. Alleviation of poverty, elimination of illiteracy and un-employment eradication of diseases and above all the development of self reliance is the motto and vision of this organization. The unending endeavor to the development process is the hall mark of Sikhya-O-Sikhya. It believes that the development process will never stop and Sikhya-O-Sikhya will never stop to provide its share in this process.

Aims & Objectives of the Organization :

The following are the aims and objectives of the society.

Most specifically, the objectives of the program for which the Sikhya-O-Sikhya is established are : -

1. To enrich the personal life of the workers and their families by providing opportunities of adult and technical education.
2. To enable the worker to play a more effective role as a member of the family and as a citizen.
3. To improve the occupational skills and technical knowledge of the worker for raising his efficiency and increasing productive ability.
4. To organize programmes of vocational and technical training with a view to facilitating horizontal/vertical mobility and employability.
5. To widen one range of his/her knowledge and understanding of the social, economic and political systems in order to create in him/her critical awareness about the environment.
6. To facilitate, restructure of Indian Society with the help of Government, NGOs and the people.
7. To work for National Integration, International Peace and Understanding.
8. To take up program/project for the helpless distressed, down-trodden and Socio-Economically Backward Classes.
9. To take up program/project on Adult Education, Mass Education, Elementary Primary and Higher Education.

10. To take up different programmes for the Welfare of Children and Women.
11. To take up projects for the welfare and rehabilitation of old people including opening up of Old-Age Home, Day Care centre etc.
12. To take up programmes/projects for the protection and development of environment, ecological system.
13. To take up Rural Development and Welfare project.
14. To take up programmes/projects for the up-liftment of Scheduled Caste, Scheduled Tribe and living Below Poverty Line.
15. To take up programs/projects for the welfare of the mentally retarded people and the disabled persons.
16. To take up vocational training programmes and to establish Women's Hostel, Nari Samities, Ladies Club and Recreational Centers.
17. To take up programmes/projects to fight pernicious diseases such as AIDs, Malaria, Leprosy etc. and to organize Health Checkup Camps, Eye Operation Camps, Family Welfare Camps and Legal Aid centers etc.
18. To take up programmes/projects on Drug Addiction and other Malicious problems.
19. To take up and organize relief camps, relief squads and ambulance services etc. and provide relief to those who have fallen victims of national calamities.
20. To take up programmes/projects on agriculture and animal husbandry.
21. To take up programmes/projects for all round development of the society.

-As Annexure VII

ABOUT THE PROJECT

PART 1

Title of the Project:

Establishment of 30 Bedded Hospital, Nursing School-cum College, Vocational Training Centre & Full fledged Mobile medical Van for the development of the targeted people of Khunta Block of Baripada, Mayurbhanj District of Odisha.

Target Group:

SC/ST, Other backward community, Minority Community living below t he Poverty Line in Khunta of Mayurbhanj District of Odisha.

Project Background:

A major population of Khunta Block of Mayurbhanj District, Odisha is socially and economically excluded. The problem of malnutrition in this area is multidimensional and intergenerational in nature. The causes of malnutrition in the Block are poverty and food insecurity, lack of awareness and gender disparity. The most common types of malnutrition prevalent in Khunta are low birth weight (LBW), protein energy malnutrition (PEM) and mineral and vitamin deficiencies (anaemia). The most vulnerable groups of malnutrition in this area are children and pregnant women.

Odisha (previously Orissa) is one of the poorest states of India. Laying in the eastern part of the country its population is 36.80 million. A large part of the state goes to rural population. Without exaggeration it can be said that Odisha lives in villages. Agriculture is the main source of livelihood among the rural people. Despite its abundant natural resources, most of its population is reeling under absolute poverty. More than 47% of its population lives below poverty line as compared to 26% of the country. Odisha has 30 districts, 314 Blocks and 51349 villages. Out of the 30, 12 districts are dominated by tribal population. Of its total population, 6.08 million are Scheduled Castes (SCs) and 8.15 million are Scheduled Tribes (STs).

Mayurbhanj is one of the 12 tribal-dominated districts. With a total geographical area of 10,418 sq. km., the district is situated in the northern boundary of the state. Being endowed with lush green vegetation, various fauna and a rich cultural heritage, Mayurbhanj takes a distinct position. It has a rich mineral base and is famous for its Similipal biosphere. It is the largest tribal district of the state. The tribes/indigenous people constitute around 58% of the total population of the district. Though the population of Mayurbhanj is only 6% of the total population of Odisha, its tribal population shares 15.42% of the latter's tribal population. Out of 62 types of tribal people living in Odisha, this district houses 53 types. The chief indigenous

groups among them are- *Bhumija, Santhal, Bhuiyan, Gond, Ho and Kolha*. The vast geographical area of the district with its valuable forest area provides a vital strength to the people for their sustainable development. The socio-economic panorama of the indigenous people of Mayurbhanj is extremely complex. Though they are socially, educationally and economically backward they have their own distinctiveness. More than 65% of the tribes in the district are below poverty line.

Most of its population depends on settled cultivation. And, a segment of its population draws its sustenance from hunting and collection of minor forest produces. Traditional pattern of cultivation, non-application of improved agricultural tools, lack of irrigation facilities, small agriculture holdings, etc contribute to overall low productivity of agriculture lands. It is a well-known fact that there is large-scale underemployment in rural areas as the people mostly depend on agriculture that is more or less seasonal in nature. Due to lack of employment opportunities, seasonal migration of these underemployed workers to the other districts within the state and districts in the bordering states Jharkhand and West Bengal occurs every year.

Education is constrained by the socio-economic conditions of the people. The percentage of literacy among Scheduled Castes (SCs) and Scheduled Tribes (STs) is 24% and 38% respectively. Due to low rate of literacy among women, SCs and STs, they do not get to reap the benefits of many welfare programmes run by the government.

The indigenous population of the district, like everywhere, is socially and economically excluded, and the exclusion leads to their low living standard. Their exclusion, mainly caste-based, is reflected in a lack of access or unequal access to political institutions, to public services (education, health care, etc) and to income-earning assets among many others. Also, across social groups, women face discrimination in many areas of life. Disadvantage is amplified when identities overlap, such that tribal women are doubly excluded, both as women and as tribal. Excluded people do not get scope to develop their human capabilities to the required extent. Due to years of neglect and exploitation, the human development indicators of the excluded groups are much lower than that of the rest of the population in terms of all parameters like livelihood, health and nutrition, education, etc. Health is major problem in the isolated areas where indigenous people live. Lack of food security, sanitation, safe drinking water and nutrition aggravate their poor health situation. The problem of malnutrition is multidimensional and intergenerational in nature.

Khunta is one of the 26 Blocks of the Mayurbhanj District. Being a unit (Block) of the district, the socio-economic profile of Khunta is no different from that of the district. The total population of the Block is just below one lakh, of which 75% is indigenous population. The Block is divided into 14 Gram Panchayats and each GP consists of on an average 4-17 villages. Here, poverty is a condition created by unjust society, denying people access to and control over the resources that they need to lead a fulfilled life. Most of the households depend on agriculture which is low on productivity due to a variety of factors, chief among them being small land holdings.

Also, agriculture does not provide employment and income throughout the year. People who own no land work as agriculture labourers. Also, people engage themselves in collection of minor forest produces and selling those in local market. Still, unemployment as well as under-employment remains as a major problem. Inadequate livelihood status of the area leads to poor health and nutrition condition of the people. Thus, they remain in a vicious cycle of poverty from generation to generation.

Table No.1

Gram Panchayats (GPs) of Khunta Block (considered as project area units)			
1.	Badafeni Panchayat	8.	Dengam Panchayat
2.	Badpathara Panchayat	9.	Dhanghera Panchayat
3.	Bahanada Panchayat	10.	Dukura Panchayat
4.	Bangara Panchayat	11.	Gadiaon Panchayat
5.	Basipitha Panchayat	12.	Karkachia Panchayat
6.	Bholagadia Panchayat	13.	Laxanasahi Panchayat
7.	Brundabanchandrapur Panchayat	14	Sapanchua Panchayat

The Mayurbhanj District is one of the backward District of Odisha State. Though several projects have been undertaken from time to time poverty issues have not been addressed in the proper perspective. Thus SOS a Social Organization working in the Baripada and Khordha District of Odisha proposes to Establish a Rural 30 Bedded Hospital Nursing schoo-cum-College, Vocational Training Centre and Full Fledged Mobile Van to reach the inaccessible area Khunta Block of Mayurbhanj District of Odisha for the socio-economic development and self employment of the BPL category people and provide health facilities to the door steps to the targeted community of the Baripada of Mayaurbhanj District. Such projects are intended to ensure different strategies through self employment, programs to provide long term sustainable self employment opportunities in terms of organization of rural people provision of support nursing training and medical facilities etc. to specific number of BPL families as well as those above the poverty line within a specific time period. The program is special because it will be beneficial for the local people.

It is the right of every individual to keep up good health as weak and diseased people cannot make a healthy and strong nation. In order to enable its citizen good health, it is the moral responsibility of the government of the day to provide adequate health services to the people, especially the tribal poor and the disadvantaged who are most often than not are denied adequate health services. In the rural and inaccessible areas of Mayaurbhanj District the public health services simply do not function regularly putting the people in great distress. The poor do not have money nor will to travel all the way to district hospital to avail of the services.

India pledged along with other WHO member Nations, 'Health for All by the Year 2000' at Alma-Ata in 1978; and in the same year signed the International Covenant for Economic, Social and Cultural Rights – Article 12, in which the State is obliged to achieve the highest attainable standard of health. However the health scenario in India is abysmal. In India, annually 22 lakh infants and children die from preventable illnesses; 1 lakh mothers die during child birth, 5 lakh people die of Tuberculosis. Diarrhoea and Malaria continue to be killers while 5 million people are suffering from HIV/AIDS. In the context of poverty, access to public health systems is critical. However, since 1990s, the public health system has been collapsing and the private health sector has flourished at the cost of the public health sector.

The larger outpatient care is almost a private health sector monopoly and the hospital sector is increasingly being surrendered to the market. The decline of public investments and expenditures in the health sector since 1992 has further weakened the public health sector thus adversely affecting the poor and other vulnerable sections of society. Introduction of user fees for public health services in many states has further reduced their access to health services.

The time has come to reclaim public health and make a paradigm shift from a policy-based entitlement for healthcare to a rights based entitlement. For this healthcare has to become a political agenda. Public health services, which reduce a population's exposure to disease through such measures as sanitation and vector control, are an essential part of a country's development infrastructure. In the industrial world and East Asia, systematic public health efforts raised labor productivity and life expectancies well before modern curative technologies became widely available, and helped set the stage for rapid economic growth and poverty reduction. The enormous business and other costs of the breakdown of these services are illustrated by the current global epidemic of avian flu, emanating from poor poultry-keeping practices in a few Chinese villages. For various reasons, mostly of political economy, public funds for health services in India have been focused largely on medical services, and public health services have been neglected. This is reflected in a virtual absence of modern public health regulations and of systematic planning and delivery of public health services. Various organizational issues also militate against the rational deployment of personnel and funds for disease control. There is strong capacity for dealing with outbreaks when they occur, but not to prevent them from occurring. Impressive capacity also exists for conducting intensive campaigns, but not for sustaining these gains on a continuing basis after the campaign. This is illustrated by the near eradication of malaria through highly organized efforts in the 1950s, and its resurgence when attention shifted to other priorities such as family planning. This paper reviews the fundamental obstacles to effective disease control in India and indicates new policy thrusts that can help overcome these obstacles.

We recognize health and education as inalienable human rights that every individual can justly claim. So long as wide health and educational inequalities exist in our country and access to essential health care is not universally assured, we would fall short in both economic planning and in our moral obligation to all citizens." These

sentiments were expressed not by an activist demanding the Right to Health but by Prime Minister Manmohan Singh. While delivering his convocation address at the All-India Institute for Medical Sciences in New Delhi recently, Dr. Singh went on to add that he believed the bulk of the provision of basic health services and medical care, specially for the poor, would continue to remain in the public domain in the near future. "Private care," he added, "cannot be the immediate answer to the needs of those who do not have basic purchasing power."

The Prime Minister's sentiments now need to be reflected in the allocation for health in our budget. Currently, India spends only 0.9 per cent of its GDP on health care in the public sector. The majority of the people are forced to turn to private health systems that are often beyond their reach. For the poor, the choice is sometimes between treatment and death. That is a choice no citizen should be forced to make.

Public health services, which reduce a population's exposure to disease through such measures as sanitation and vector control, are an essential part of a country's development infrastructure. In the industrial world and East Asia, systematic public health efforts raised labor productivity and life expectancies well before modern curative technologies became widely available, and helped set the stage for rapid economic growth and poverty reduction. The enormous business and other costs of the breakdown of these services are illustrated by the current global epidemic of avian flu, emanating from poor poultry-keeping practices in a few Chinese villages. For various reasons, mostly of political economy, public funds for health services in India have been focused largely on medical services, and public health services have been neglected. This is reflected in a virtual absence of modern public health regulations and of systematic planning and delivery of public health services. Various organizational issues also militate against the rational deployment of personnel and funds for disease control. There is strong capacity for dealing with outbreaks when they occur, but not to prevent them from occurring. Impressive capacity also exists for conducting intensive campaigns, but not for sustaining these gains on a continuing basis after the campaign.

Maternal and child health is the basic and essential indicator for the well being of any society. Maternal and child health forms the basic measure to gauge a society’s health. It is universally accepted practice which is followed by UN agencies all over the world to measure health any society of community.

The IMR is the key to know and understand any society. The status of health and well being of women and children in developed countries is well taken care whereas in the developing countries especially Asia and Sub Saharan regions the condition of the women and children extremely poor and pathetic. As could be seen that the Infant Mortality Rate is one of the highest in these regions. There are so many socio, economic and cultural reasons contribute to the status of women and children.
In the Indian context, although the maternal and children health a much to be desired, there is also a great imbalance and disparity in the status of health of women and children among the states for example the health indicators of in respect of women and children in states like Kerala is comparable to any developed countries. But the

condition of women and children in Northern India is lot to be desired. Although literacy and population are one of the impediments to better health delivery systems and sanitation facilities across the states in India, lack of institutional support to lend proper health care is also a major factor.

India at present witnessing mushrooming hi-tec specialized institutes for heart care, eye care and a host of hospitals making foreigners to come to India for specialized treatment. Similarly, medical insurance which was a fledgling business a decade ago now grew into a huge industry where even foreign companies are competing. While these are the changes that are taking place in a rapid speed the health and sanitation condition of the poor and the underprivileged who are placed especially in Indian rural areas remain the pathetically the same. In fact, their condition had been deteriorated over the years.

Although the Five Year Plans implemented since the dawn of Independence gave a great impetus to primary and community health needs to the millions of Indian population, the institutional health care and facilities are lopsided and not evenly spread to the rural areas. Even after five decades of Independence, basic health care is a distant dream to many Indian villages.

These apart, health care especially preventable and primary health care facilities are becoming an expensive one to the common man. The availability of primary health centers, district level hospitals and referral centres although exist in every state and district, the actual requirement to the hundreds and thousands of villages is nowhere near to it.

Similar to health, education is one of the important indicators that reflect the health of a community. The well being of a community is determined by the level of education and awareness of the people and hence developed and developing communities are attaching great importance to education especially basic education. In the context of Odisha which is predominant population living below the poverty line, basic health assumes great relevance.

Health and health care need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Heath is clearly not the mere absence of disease. Good Health confers on a person or group’s freedom from illness - and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care. and current bio-medical understanding about health and illness.

What makes for a just health care system even as an ideal? Four criteria could be suggested- First universal access, and access to an adequate level, and access without excessive burden. Second fair distribution of financial costs for access and

fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system. Third training providers for competence empathy and accountability, pursuit of quality care and cost effective use of the results of relevant research to provide special attention to vulnerable groups such as children, women, disabled and the aged.

In context of poverty, access to public health systems is critical. However, since 1990s, the public health system has been collapsing and the private health sector has started flourishing due to both increases in the affordability by the common people on the one hand and improving specialization on the other. Health policy in India has shifted its focus from being a comprehensive universal healthcare system as defined by the Bhore Committee (1946) to a selective and targeted program based healthcare policy with the public domain being confined to family planning, immunization, selected disease surveillance and medical education and research.

The larger outpatient care is almost a private health sector monopoly and the hospital sector is increasingly being taken over by private sector for various socio, economic and cultural reasons especially in the urban scenario. The decline of public investments and expenditures in the health sector since 1992 has further weakened the public health sector thus adversely affecting the poor and other vulnerable sections of society. Introduction of user fees for public health services in many states has further reduced their access to health services.

In general predictions about future health - of individuals and populations - can be notoriously uncertain. However all projections of health care in India must in the end rest on the overall changes in its political economy - on progress made in poverty mitigation (health care to the poor) in reduction of inequalities (health inequalities affecting access/quality'), in generation of employment /income streams (to facilitate capacity to pay and to accept individual responsibility for one's health). in public information and development communication (to promote preventive self care and risk reduction by conducive life styles) and in personal life style changes (often directly resulting from social changes and global influences). Of course it will also depend on progress in reducing mortality and the likely disease load, efficient and fair delivery and financing systems in private and public sectors and attention to vulnerable sections of the society.

Historically the Indian commitment to health development has been guided by two principles-with three consequences. The first principle was State responsibility for health care and the second (after independence) was free medical care for all (and not merely to those unable to pay). The first set of consequences was inadequate priority to public health, poor investment in safe water and sanitation on and to the neglect of the key role of personal hygiene in good health, culminating in the persistence of diseases like Cholera. The second set of consequences pertains to substantially unrealized goals of National Health Policy 1983 due to funding difficulties from compression of public expenditures and from organizational inadequacies. The ambitious and far reaching NPP - 2000 goals and strategies have however been formulated on that edifice in the hope that the gaps and the inadequate would be

removed by purposeful action. Without being too defensive or critical about its past failures, the rural health structure should be strengthened and funded and managed efficiently in all States by 2005. This can trigger many dramatically changes over the next twenty years in neglected aspects or rural health and of vulnerable segments. The third set of consequences appears to be the inability to develop and integrate plural systems of medicine and the failure to assign practical roles to the private sector and to assign public duties for private professionals.

To set right these gaps demanded patient redefinition of the state's role keeping the focus on equity. But during the last decade there has been an abrupt switch to market based governance styles and much influential advocacy to reduce the state role in health in order to enforce overall compression of public expenditure an reduce fiscal deficits. People have therefore been forced to switch between weak and efficient public services and expensive private provision or at the limit forego care entirely except in life threatening situations, in such cases sliding into indebtedness.

Health Sector – Achievements so far...

Our overall achievement in regard to longevity and other key health indicators are impressive but in many respects they are uneven across States. For example the crude birth rates have dropped to 26.1. And death rates to 8.7. Similarly, in the past five decades life expectancy has increased from 50 years to over 64 in 2000. IMR has come down from 1476 to 7.

Reduction in child mortality involves as much attention to protecting children from infection as in ensuring nutrition and calls for a holistic view of mother and child health services. The cluster of services consisting of antenatal services, delivery care and post mortem attention and low birth weight, childhood diarrhoea and ARI management are linked priorities. Program of immunization and childhood nutrition seen in better performing stats indicate sustained attention to routine and complex investments into growing children as a group to make them grow into persons capable of living long and well Often interest fades in pursuing the unglamorous routine of supervised immunization and is substituted by pulse campaigns etc. Which in the long run turn out counter-productive? Indeed persistence with improved routines and care for quality in immunization would also be a path way to reduce the world's highest rate of maternal mortality.

Health Sector: the present scenario:

India has one of the largest health infrastructure set up with over 5 lakh trained doctors working under plural systems of medicine and a vast frontline force of over 7 lakh ANMs, MPWS and Anganwadi workers besides community volunteers. The creation of such public work force should be seen as a major achievement in a country short of resources and struggling with great disparities in health status. As part of rural Primary health care network lone, a total of 1.6 lakh sub-centers, (with 1.27 lakh ANMs in position) and 22975 PHCs and 2935 CHCs (with over 24000 doctors and over 3500 specialists to serve in them) have been set up. To promote Indian systems of medicine and homeopathy there are over 22000 dispensaries 2800 hospitals Besides

6 lakh angawadis serve nutrition needs of nearly 20 million children and 4 million mothers. The total effort has cost the bulk of the health development outlay, which stood at over Rs 62.500/- crores or 3-64 % of total plan spending during the last fifty years.

On any count these are extraordinary infrastructural capacities created with resources committed against odds to strengthen grass roots. There are facility gaps, supply gaps and staffing gaps, which can be filled up only by private partnership as the Government has its limitations both in terms of resources and managing efficiency.

One key task in the coming decades is therefore to utilize fully that created potential by attending to well known organizational motivational and financial gaps. The gaps have arisen partly from the source and scale of funds and partly due to lack of persistence, both of which can be set right. PHCs and CHCs are funded by States several of whom are unable to match Central assistance offered and hence these centers remain inadequate and operate on minimum efficiency. These are the real important gaps where private partnership can go a long way in ensuring highest efficiency and health delivery mechanisms.

Disease Load in India – a challenge…

Among the nations of the world China alone rank in size and scale and in complexity comparable to India differences between an open and free society and a semi-controlled polity do matter. The remarkable success in China in combating disease is due to sustained attention on the health of the young in China, and of public policy backed by resources and social mobilization- While comparing China and India in selected aspects of disease load, demography and public expenditures on health, the record on India may seem mixed compared to the more all round progress made by china. But this should also be seen in the perspective of the larger burden of disease in India compared to china and of the transactional costs of an open and free democracy,

Though India and China recorded the same rate of growth till 70s, China initiated reforms a full decade earlier. This gave it a head start for a higher growth rate and has resulted in an economic gap with India which has become wider over time. This is because domestic savings in China are 36% of GDP whereas in India it hovers at 23%, mostly in house-hold savings. Again. China attracted $40 billion in foreign direct investment against $2 billion in India. Special economic zones and relaxed labour laws have helped. Public expenditure on health in China has been consistently higher underlining the regressive natures of financing of health are in India. Nevertheless- it is not too unrealistic to expect that India should be able to reach by 2010 at least three fourth the current level of performance of China in all key health indices. India's current population is not a bit more than 75% that of China and India will of course be catching up even more with China into the 21 century. This would be offset by the handicap that Indian progress will be moderated by the fact that it is an open free and democratic society. A practical rule-of-thumb measure for an optimistic forecast of future progress in India could be - that between 2000 and 2010 India should do three fourths as well as China did in 1990-2000 and, after 2010, India

should try to catch up with the rate of performance of China and do just as well thereafter. This will translate into, for, instance, a growth rate of about 8% for India till 2010 and as close to 10% as possible thereafter thus enabling doubling first in ten yeas and doubling first in ten year and doubling twice over every seven years thereafter prior to 2025. keeping this perspective in mind, we may now examine the profile of major disease control effort; the effectiveness of available instruments for delivery and financing public health action and assess factors relevant to the remaining event of vulnerability within JOUT emerging social pyramid over next two or three decades.

Health infrastrucutre: Private parnership – a paradigm shift…

Issues in regard to public and private health infrastructure are different and both of them need attention but in different ways. Rural public infrastructure must remain in mainstay for wider access to health care for all without imposing undue burden on them. Side by side the existing set of public hospitals at district and sub-district levels must be supported by good management and with adequate funding and user fees and out contracting services, all as part of a functioning referral net work. This demands better routines more accountable staff and attention to promote quality. Many reputed public hospitals have suffered from lack of autonomy inadequate budgets for non-wage O&M leading to faltering and poorly motivated care. However, lack of funding, supervision and efficiency at different levels of health management lead to the spurt of private partnership and growth of private hospitals and dispensaries including super specialized hospitals all across the country. In a way, this is the logical development in health care management in vast country like India as easier access to health care facilities should be the basic guiding principle. Having understood the paradigm The Multi-disciplinary Hospital-Cum-Nursing College was formed essentially to render basic health services including preventive and curative health care services to the urban middle and lower class people at a nominal fee. As such, the hospital was formed and functioning quite efficiently and this proposal is to seek financial assistance to improve the basic services with appropriate infrastructure and facilities including purchase of machineries and gadgets.

Feasible Steps for better performance

In the event of dwindling central government budgets for health care facilities and changes in the state government priorities, the existing health care system need to be revamped with greater participation of private parties, people's initiatives and community participation with greater accountability and efficiency. The inefficient and quite absence of the PHCs and CHCs both in rural and urban areas has lead to mushrooming private clinics and dispensaries. On quality standards, most of these clinics are doing exceptionally well especially in diagnostics and dispensing treatments in contrast to government hospitals and dispensaries. However, the challenge is to bring efficient systems in place and bringing down the cost of medical care affordable to all.

The persistent under funding of recurring costs had led to the collapse of primary care in many states, some spectacular failures occurring in malaria and Dengu control. This has to do with adequacy of devolution of resources and with lack of administrative will probity and competence in ensuring that determined priorities in public health tasks and routines are carried out timely and in full. Only genuine devolution or simpler tasks and resources to panchayats, where there will be a third women members- can be the answer as seen in Kerala or M.P. where panchayats are made into fully competent local governments with assigned resources and control over institutions in health care. Many innovative cost containment initiatives are also possible through focused management - as for instance in the streamlining of drug purchase stocking distribution arrangements in Tamil Nadu leading to 30% more value with same budgets. Private sectors hospitals and dispensaries also could bring perceptible changes in hospital management, diseases surveillances, patient care, etc.

Healthcare financing systems

Fair financing of the costs of health care is an issue in equity and it has two aspects how much is spent by Government on publicly funded health care and on what aspects? And secondly how huge does the burden of treatment fall on the poor seeking health care? Health spending in India at 6% of GDP is among the highest levels estimated for developing countries. In per capita terms it is higher than in China Indonesia and most African countries but lower than in Thailand. But over the years, this high spending by Government has been dwindled down due to various economic policy changes. This has lead to the emergence of private partnership in health care sector and the proposal by Indian Hospital is in line with the ongoing trend bring affordable health care facilities to the poor in urban areas. Simultaneously, this has also leaded to face the challenges of bringing new trends and technological advancements to health care facilities.

There are nearly 2000 owned and managed by charitable trusts, received partial support from the government, and the remaining 1,300 hospitals, many of which were relatively small facilities, were owned and managed by the private sector. The use of state-of-the-art medical equipment, often imported from Western countries, was primarily limited to urban centers in the early 1990s. A network of regional cancer diagnostic and treatment facilities was being established in the early 1990s in major hospitals that were part of government medical colleges. By 1992 twenty-two such centers were in operation. Most of the 1,300 private hospitals lacked sophisticated medical facilities, although in 1992 approximately 12 percent possessed state-of-the-art equipment for diagnosis and treatment of all major diseases, including cancer. The fast pace of development of the private medical sector and the burgeoning middle class in the 1990s have led to the emergence of the new concept in India of establishing hospitals and health care facilities on a for-profit basis. The key features of the private sector in medical practice and health care are well known. Two questions are relevant. What role should be assigned to it? How far and how closely should it be regulated? Over the last several decades, independent private medical practice has become widespread but has remained stubbornly urban with polyclinics, nursing homes and hospitals proliferating often through doctor entrepreneurs. At our

level tertiary hospitals in major cities are in many cases run by business houses and use corporate business strategies and hi-tech specialization to create demand and attract those with effective demand or the critically vulnerable at increasing costs. Standards in some of them are truly world class and some who work there is outstanding leaders in their areas. But given the commoditization of medical care as part of a business plan it has not been possible to regulate the quality, accountability and fairness in care through criteria for accreditation, transparency in fees, medical audit, accountable record keeping, credible grievance procedures etc. such accreditation, standard setting and licensure systems are best done under self regulation, but self regulation systems in India medical practice have been deficient in many respects creating problem in credibility. Acute care has become the key priority and continues to attract manpower and investment into related specialty education and facilities for technological improvement. Common treatments, inexpensive diagnostic procedures and family medicine are replaced and priced out of the reach of most citizens in *urban* areas.

The basic thing is to provide public health facilities with a thrust area of Baripada of Mayaurbhanj district of Odisha taken at the community level, reducing the incidence of disease in all its spheres. The proposed hospital, Nursing School-Cum-college, Vocational Training Centre and Full fledged Mobile Medical Van will cater to the needs of the poor and the marginalized people of Mayurbhanj District of Odisha state. The hospital will cater to the needs of the poor and the marginalized with a special focus on maternal and child health through series interventions built around the hospital and research initiatives which can be built around local specific health concerns. The proposed hospital will be functioning as a centre for referral services and there will be a multi-pronged approach in each units of the hospital to address local specific health issues throughout the Mayurbhanj District. The general flow of the project will be a systematic approach to address the health concerns of the people starting with sanitation, environment, disease prevention and public health issues. In general the hospital will address the following issues:

- Basic Health Services;
- Maternal and child health
- Immunization and nutrition of children
- Contagious diseases and public awareness
- Reproductive health and HIV/AIDS & STI
- Preventive diseases control
- Building institutions for education and health
- Special care for the poor and the marginalized
- Research and referral services to poor on emerging diseases
- Sustained institutional set up and arrangements for local specific health concerns and issues, etc.

Background of the area:

It is proposed to set up a 30 bedded hospital with a special focus on women and children would be a parallel medical delivery system in Mayurbhanj district of Odisha for people who have no access to quality medical services. It is proposed to establish a 30 bedded hospital with Outpatient Department and emergency service facilities to cater to the needs of the people living Mayurbhanj District. The society also intends to treat the general public besides the women and children for whom it will have a trained and specialized medical force including health activists. The proposed hospital would be a specialized hub for medical facilities for the poor as well as Nursing training centre for Socio-economic weaker people and also resource centre for practicing health activists.

The hospital will be a full-fledged institution which is established in Khunta Block of Mayurbhanj District that would provide treatment and medical facilities to not only in an outpatient department but also provide institutional 30 bedded facilities to the women and children including administering vaccines to children. The entire services tendered including dispensing medicines and administering medical services will be free of cost. The society will make necessary arrangements to acquire land for the proposed hospital and any short of it would be raised through community donation and the Society requires assistance for only construction, infrastructure and running cost of the hospital including purchase of medicines, recruitment of professionals and para medical employees, and rendering community services through mobile van arrangements or through village extension centers and outreach programs across all the villages of Baripada, Mayurbhanj districts of Odisha.

The proposed rural hospital for women and children would work in tandem with other existing government and private medical institutions and the district/state referral centre. The proposed hospital would essentially strive to provide an innovative community based treatment and medical delivery system to the people and also would try to foster indigenous medical systems with a special focus on the health and well being rural women and children.

The program also intends to launch Female Health Workers in all villages and hamlets of Mayurbhanj district of Odisha. The main duties and responsibilities of the Female Health Workers will be:

- To live in the village allotted to her and run a Sub-centre with medicines and other necessities provided to her at the Sub-centre.
- To provide First Aid and emergency services;
- To look after RCH specifically and assist in regular health checkups of the pregnant women and during the delivery.
- To look after the immunization of children.
- To educate young mothers in childcare.

- To provide information about spacing childbirth and use of contraceptives.
- To undertake activities with reference to malaria.
- To educate villagers about nutritious food.
- To inform people about infectious diseases.
- To upgrade the skills of the Traditional Birth Attendants (TBA).
- To help in preventive and curative activities.
- To participate in National Health programs.
- To keep records and reports of the health profiles of patients and treatment administered to them.

Many rural people did not know about the services set up for them at sub-centers by the government because they did not see any evidence of these services being provided for them. As a part of the awareness program an exposure trip will be organized to nearby hospitals and even state referral hospitals at Mayurbhanj. It is there that the women will be informed about the specifics of various services supposed to be made available to them. This will encourage women to ask questions and report on the situation in their PHC.

Women & Maternal Health:

For women, the right to health is even more important as for a variety of reasons both choice and access are often denied to them. This was one of the dominant themes at the recent International Women and Health Meeting (IWHM) in New Delhi that brought together over 600 people, mostly women, from over 60 countries.

In fact, would have endorsed the views of the women at the meeting as they presented evidence of the consequences of the denial of health care to women. The impact of war, conflict and violence, in particular, was a major focus as several delegates came from nations that were still caught in conflict situations or had only recently emerged from the battering of a major war or upheaval.

But women face others forms of violence daily. Much of this is within the home. Some of it is external, the result of developmental policies that displace them, impoverish them and their families that increase their burden of work, that force them into low-paying hazardous jobs. Even the better-paying jobs, such as those in the Special Economic Zones, come with a price tag for women's health.

The idea of a right to health should foreground policy debates on health care. It would mean recognizing that apart from access and affordability, women also need to be guaranteed choice, particularly in matters of reproductive health. That non-discrimination is essential for effective health intervention in the face of the growing incidence of HIV/AIDS in India. Those livelihoods are as important as health infrastructure.

Proposed facilities:

The hospital since its establishment could move forward at a steady pace and could build basic essential and in some cases ultra modern and even sophisticated gadgets right from diagnostic to treatment. The following are the facilities that are in place since the hospital become functional:

Gynecology:

- Deliveries
- Caesarian
- Safe abortions
- Gynae operation theatre

Pediatric:

- Nursery
- Vaccination
- Nebulizer
- Epilepsy clinic
- Thalassemia
- Asthma clinic
- Adolescent clinic
- All Pediatric surgeries

Medicine:

- General medicine
- Diabetic & hypertension clinic
- Chest & cardiac OPD
- Epilepsy
- Kidney & renal diseases

Orthopaedic:

- Fracture clinic
- Pain clinic for joint pains
- 24 hrs. plaster facilities
- Joint replacement
- C-Arm machine

General Surgery:

- ICU
- Laparoscopic surgeries

Skin Clinic:

- Skin care

Physiotherapy:

- Cervical & lumbar tractions
- Wax bath
- IFT
- Short wave diathermy
- Ultrasound
- Muscle stimulation
- Muscle strengthening
- Joint mobilization

Diagnostics:

- X-ray
- Ultrasound
- Color Doppler
- Echo/ERCP
- TMT, EEG, PFT, CT
- MRI facilities.

Emergency:

- Ambulance Service
- Trauma Management
- Dispensary/Chemist

The salient features of Multi-disciplinary Hospital Centre are the following:

1.	30 bedded ultramodern beds
2.	Wide range of accommodation with beds
3.	Two major Operation theatres with zero bacteria. Fully equipped for all major operations including Neurosurgery, burs and plastic surgery, knee replacement surgery, etc. also with the new born baby resuscitation station provided with the each operation theatre individually managed round the clock by pediatrician.
4.	Separate labor room fully equipped with fetal heart monitoring machine (Fetal Cardio Topography) with the twins monitoring system at the same time with new born baby resuscitation station with the labor room individually managed round the clock by the pediatrician.
5.	Baby nursery with incubators, phototherapy machine for jaundice management, radiant warmers, pulse ox meter.
6.	Separate MTP and pre labor room
7.	ICU with defibrillators, cardiac monitors, oxygen concentration machine
8.	Special Burns unit with state of the art machineries and equipments
9.	Special Trauma unit with ambulance facilities
10.	Computerized laboratory for all investigations.
11.	Emergency unit with attached Minor OT equipped to deal with every emergency round the clock
12.	Physiotherapy unit fully equipped with round the clock physiotherapist and weight loss equipments.
13.	Dental center
14.	Modern X-ray plan and imaging technologies
15.	Latest Color Doppler machine with all probes functioning 24 hours
16.	Latest Echo Cardiograph machine with functioning 24 hours.
17.	Oxygen concentration machine making oxygen to ensure 24 hours supply
18.	24 hours Ambulance service
19.	24 hours computerized E.C.G. unit
20.	24 hours Pharmacy/Chemist shop
21.	Skin care, Electrolyses and cosmetic treatment
22.	Multi-specialty OPD wing: 1000 am to 0200 pm & 0500 pm to 0800 pm
23.	Emergency OPD wing: 0200 pm – 0500 pm & 0900 am to 1000 am
24.	Breast Clinic (Early Detection of Breast and Cervical Cancer)
25.	Well baby clinic
26.	CU-T Family Planning & Safe Delivery & MTP
27.	Laparoscopic Gall Bladder Removal & Tubectomy
28.	Nebulisation for Asthma patients
29.	Fracture Clinic with major Orthopedic Surgeries with latest Cram machine
30.	Vaccinations
31.	60 KV Auto Generator back-up

The following are the major departments/disciplines available with state of the art facilities and expert medical professionals:

1) General Medicine
2) General Surgery
3) Dental & Oral Care
4) Urology
5) Pediatric Surgery
6) Endoscopic Procedures
7) Pulmonary & Meditational
8) Plastic Surgery
9) Ophthalmology
10) Orthopedics
11) Gynecology
12) OPD
13) ENT
14) Anesthesiology
15) Speech Therapy
16) Audiology
17) Miscellaneous Procedures
18) Psychiatry
19) Package for Lab Operations
20) Vaccination charges
21) Diagnostics

The Multi-disciplinary Hospital – Nursing College also offer various health packages and Schemes for people with different ages and needy groups:

- Comprehensive Health Check-up;
- Eye Check-up centre;
- Executive Health Check-up;
- Routine Health Check-up;
- Pre Employment/Domestic Help Health Check-up;
- Senior Citizen Health Check-up;
- Women Health Check-up;
- Child Health Check-up
- Newborn Baby Health Check-up.

Nursing College:

The project constitutes sophisticated one hospital having the capacity of 30 bedded to be set up in Khunta Block of Baripada, Mayaurbhanj District of Odisha State in measuring five acres of Land. The hospitals shall have nursing college of their own cater the requirements of nursing staff at hospitals and shall never have any shortage of nursing staff, which is a perpetual problem these days faced by all hospitals. Services of highly qualified and experienced doctors from within and outside the country shall be taken and possible try to get these hospitals patronized by medical institute of repute. Emphasis will be laid upon research with full co-operation amongst themselves and in accordance with the guidelines of world health organization (WHO) to achieve the goal of **"Health of ALL".**

Nursing Professionals play an important role in the health care delivery system. There is acute shortage of qualified nurses in the country both for nursing services and education. Further, there is need to further strengthen the roles of nurses and hence, to start relevant educational program was acute.

The main objective of the Establishing of Nursing College is to provide a technical education to the unemployed youth through which the student nurses will be prepared to assume responsibility in the primary, secondary and tertiary care of people as professional nurses. The graduates will also be capable of teaching and supervising student nurses in providing safe and quality health care in different settings and participate in administration of nursing services and education.

Nursing Education:

We believe that nursing education is the generation, transmission, and creative use of knowledge for practice, the augmentation of health, and continuous improvement in health care. We are committed to provide world class education and quality oriented training to prepare global leaders in nursing for comprehensive nursing care in hospital and in the society.

Nurse education consists in the theatrical and practical training provided to nurses with the purpose to prepare them for their duties as nursing care professionals. This education is provided to nursing students by experienced nurses and other medical professionals who have qualified or experienced for educational tasks. Most countries offer nurse education courses that can be relevant to general nursing or to specialized areas including mental health nursing, pediatric nursing and post-operatory nursing. Courses leading to autonomous registration as a nurse typically last four years. Nurse education also provides post-qualification courses in specialist subjects within nursing.

During past decades, the changes in education have replaced the more practically focused, but often ritualistic, training structure of conventional preparation.

Nurse education integrates today a broader awareness of other disciplines allied to medicine, often involving inter-professional education, and the utilization of research when making clinical and managerial decisions. Orthodox training can be argued to have offered a more intense practical skills base, but emphasized the handmaiden relationship with the physician. This is now outmoded, and the impact of nurse education is to develop a confident, inquiring graduate who contributes to the care team as an equal. In some countries, not all qualification courses have graduate status.

Scope of nursing in India:

There was a time when professional nurses had very little choice of service because nursing was centered in the hospital and bedside nursing. Career opportunities are more varied now for a numbers of reasons. The list of opportunities available is given under:

- Staff Nurse provides direct patient care to one patient or a group of patients. Assists ward management and supervision. She is directly responsible to the ward supervisor.
- Ward sister or Nursing Supervisor, She is responsible to the nursing superintendent for the nursing care management of a ward or unit. Takes full charge of the ward. Assigns work to nursing and non-nursing personnel working in the ward. Responsible for safety and comfort of patients in the ward. Provides teaching sessions if it is a teaching hospital.

1. Department supervisor/Assistant Nursing Superintendent. She is responsible to the nursing superintendent and deputy nursing superintendent for the nursing care and management of more than one ward or unit. Example – Surgical department. Out-patient department.
2. Deputy nursing superintendent. She is responsible to the nursing superintendent and assists in the nursing administration of the hospital.
3. Nursing Superintendent She is responsible to the medical superintendent for safe and efficient management of hospital nursing services.
4. Director of Nursing She is responsible for both nursing service and nursing educations within a teaching hospital.
5. Community Health Nurse (CHN) services rendered mainly focusing Reproductive Child Health program.
6. Teaching in nursing. The functions and responsibilities of the teacher in nursing are planning, teaching and supervising the learning experiences for the students. Positions in nursing education are clinical instructor, tutor, senior tutor, lecturer, and associate professor, Reader in nursing and Professor in nursing.
7. Industrial nurse Industrial nurses are providing first aid, care during illness, health educations about industrial hazards and prevention of accidents.

8. Nursing service abroad Attractive salaries and promising professional opportunities, which cause a major increase for nursing service in abroad.
9. Nursing service administrative positions. At the state level the Deputy Director of Nursing at the state health directorate. The highest administrative position on a national level is the Nursing Advisor to the Govt. of India.
10. Nursing leadership is not at all in India. there must be need of the strong leaders in India which may make the nursing level high. At this time India is suffering from the lack of good and actual leader in nursing.

Outreach:

The College of Nursing established and provides leadership to the Continuing Education Consortium, which is a group of nurse educators in the local area. The College organizes staff development programs, such as the Critical Care Course, to increase the quality and effectiveness of health care and to meet the needs of participating hospitals.

The mission of the College of Nursing is to promote society's health, and this is actualized through service learning projects that benefit the citizens of Tennessee and beyond. For example, the college maintains a nurse-managed clinic at the Vine Middle School and faculty and students provide health care services for the homeless at the Volunteer Ministry Center. Service learning projects are associated with nearly every clinical course, and there are many more opportunities for service learning than we can accept. One challenge is the complexity of the arrangements for these projects which are often time-intensive to formalize. A dedicated 0.5 FTE clinical faculty line to arrange and monitor service learning activities would ensure that all projects are appropriate for the intended audience and contracts and/or agreements are in place.

Our Values:

- The College believes in the work and worth of the nursing profession and demonstrates this by the range of services provided to support and sustains it.
- The College promotes a voice for nurses in determining the direction and future of health care delivery.
- The College promotes respect and support regardless of difference and acknowledges individual efforts and achievements.
- The College is committed to continuous quality improvement as a dynamic process of innovation and renewal.
- The College acts with integrity to ensure accountability.
- The College is committed to lifelong learning.
- The College is committed to developing partnerships and strategic alliances for the benefit of the profession.

- The College encourages an environment of critical inquiry and research-based teaching and management.

Our Focus:

- The College of Nursing provides support for nurses, while contributing to the creation of a better health care system for the people.
- These goals are achieved through education and professional development for all nurses, and by contributing to policy making with relevant health organizations.
- The College of Nursing represents nurses at all stages of their careers, providing access to the latest information on nursing practice and giving support to facilitate career advancement.
- This focus leads to continuing benefits for health care systems through developing greater awareness of the significance of nursing to other health professionals and the wider community.

Areas of improvement proposed...

The major tasks and challenges before any health institution whether government or private are as follows:

1) Building major disease control efforts in and around the hospital area;
2) Confronting re-emergence of communicable diseases like Kala ajar, malaria, filariasis, STDs & HIV/AIDS in the urban context;
3) Building institutional support for common preventive and curative diseases with special focus on the socially and economically vulnerable groups of population;
4) Containing diseases like Tuberculosis; leprosy and bringing in sustained institutional efforts to eradicate them;
5) Maternal health and safe motherhood issues with partnership with research institutions while making affordable all facilities to the poor and the needy;
6) Child health and nutrition right from neonatal stage; bringing out all round development of children without any gender bias;;
7) Health care in urban centric population and addressing health and sanitation issues specific to urban areas;
8) Improving diagnostic techniques and bringing sophistication with an eye on cost reduction;
9) Improving the existing disease surveillance techniques in the urban context;
10) Special focus on geriatric and care for the elders including rendering community based services;

11) Special focus and efforts for the disabled, special need groups and children of the underprivileged;

12) Building linkages to health, environment and sanitation issues;

13) Achieving highest efficiency in health care and advancing specialization;

14) Building standards in public health and dispensing specialized medication;

15) Helping to achieving the UN goal of `Health for all by 2000' in every possible sphere of activities.

Outcome of the Project:

- ✓ Unemployed youth technical educated.
- ✓ More awareness in health related matters.
- ✓ Socio-economic sustainability.
- ✓ Increased Health Seeking Behavior;
- ✓ Better health status in the community;
- ✓ Social awareness on socials stigmas and the misconceptions
- ✓ Reaching to the un reached and providing the chances to know things
- ✓ Facilitate and to provide chances to the medical as well as the social candidates to make a better man for the welfare of the society.
- ✓ Positive impact on the family of health atmosphere;

Justification of the Project:

- We are putting this strain to make the right to sight to all and we have witnessed the in our nation itself that because of the lack of the treatment and the hospital availability many of our brethren lost their sight and we never want to do the same in our nation anymore.
- Comprehensive eye care services. This is a comprehensive approach incorporating preventive, curative and rehabilitation services.
- The objective of the program is to provide high quality, sustainable, comprehensive health care by developing primary and secondary level service providers, developing innovative community participatory programs to aid uptake of services, integrating components of primary health care and primary eye care, and utilizing management and geographic information systems to aid service delivery.
- The positive impact of the project will be evident in the area and in the living people the district, the state and in the nation itself.

Objective:

1. To create employment opportunity for unemployed youth on health technology.
2. To provide basic health facilities and medical care to the poor and the marginalized communities;
3. Creating conducive environment for community health to specialized health care for the marginalized communities;
4. to address key health concerns of the common public and deprived communities;
5. To work with the community for a disease free Odisha;
6. To launch multi-pronged approach in health care facilities and infrastructure in Baripada of Mayurbhanj District;
7. To provide 100% free education to at least 30% of the total beneficiaries of the project (Free education will be provided to the beneficiaries from weaker section of the society)
8. To work for the empowerment of the poor and the marginalized through better health and well being;
9. To address the local specific issues of sanitation, public health and community well being through an institutional mode;
10. To engineer social concern and social responsibility among the stakeholders by addressing the health concerns of the poor;
11. To build institutions for education and health all over the districts;
12. To deliver preventive and primary health care facilities to the rural women and children;
13. To arrange affordable health care facilities at free cost through community based and community owned institution;
14. To provide institutional health delivery system to women and children;
15. To address community health concerns through community based institutional efforts;
16. To provide effective outpatient services including emergency services to the rural poor;
17. To provide effective and innovative institutional support community health and sanitation through trained doctors and well placed facilities;
18. To provide outreach program to distant rural areas through mobile clinics;
19. To train and deploy health activists for village counseling and help;
20. To learn and foster indigenous health practices through community monitoring and learning.

21. To strive to promote a disease free rural communities in Baripada of Mayurbhanj District. Odisha.
22. To prepare nurse clinicians for bedside and family care nursing, nursing supervision and nursing administration.
23. To prepare nursing teachers for Schools of Nursing to train Multipurpose Health Workers and General Nurse Midwives (GNM) and for University level nursing education.
24. To prepare nursing personnel to conduct research related to delivery of nursing care services.
25. To prepare nursing personnel to develop nursing literature.
26. Demonstrate leadership and administrative skills in working with the health care team, community and others in the provision of health care.
27. Practice ethical values in personal and professional life.
28. Exhibit a Scientific attitude of independent enquiry into nursing problems

Vocational Training Centre:

Importance of Vocational Training:

The economy's the world over are changing into knowledge based economies. The changing face of technology the world over requires an individual to be specialized in a particular skill. Only a person who is expert in a particular field can get a good job. Vocational education training institutes impart specialized and practical knowledge to a person and help them become independent at a particular age.

Vocational education training can be provided for a number of courses like health, technical, art, administration and other courses. These subjects can be further classified into specialized courses. For example, health can be divided into massage therapy, dietitians, and nutritionist. Any person can select any course of his choice and inclinations.

Vocational education training institutes impart graduation and post graduation courses to students. The best part of the institute is that even working people can join the course, and even select the timings as per their convenience and nature of job. The vocational institutes allow the students to study online and attend either evening or morning classes. Moreover, financial aid is provided to students who are economically weak.

The faculty of these Vocational education training institutes is highly experienced. They impart practical knowledge to their students. As a result the students are able to have a real life and practical industry experience. The students are also provided with internships.

They are also provided with stipend for their internships. This gives motivation to perform better and excel in their jobs.

They do their job under the supervision of an expert. It is a great learning experience for them as it helps them perform in their job better. For working professionals it is a way to hone their skills while making money.

There are various vocational education training located the world over. In fact every state has vocational institutes where the residents of the place can earn the degrees and become part of a specialized workforce. Majority of these training institutes work as per the rules and regulations of state education department. It is the education department of state or the central government that grants recognition to a training institute.

A training institute is required to follow the rules or else its recognition can be cancelled. It is necessary that a person fulfills the eligibility criteria of the training institute. The procedure of getting admission into any vocational institute is very simple and easy. For any detailed information you can visit the site and get to know about the institute and their placement policies. Also, it is necessary that the vocational institute that you select should be recognized by the concerned education department. The placement of an institute is an indicator of the quality of vocational training institute.

- The course structure of the training institute is regularly updated. This is because the technology and the fundamentals of economy are changing very rapidly. Providing practical knowledge based on the old concepts does not make sense.
- The opportunity for higher education is very much limited in our area. Due to economic constraints of the family, the students are not able to education in faraway places/ institutions. Hence they have no scope for better employment opportunities. So they are forced to do unskilled jobs which bring them nominal income that they never come to the forefront of the mainstream of society.
- As most of the students from these communities are dropouts at upper primary / high school level, they are not legally/ technically eligible to enroll themselves for higher education. It is also a cause for unemployment among them.
- Due to many reasons, the students from backward communities may not always be able to keep the standard of other students. They need special attention and care from the instructor/teacher. In a formal setting it is not possible for the instructor to impart special attention to them. The formal institutions are generally giving more importance on theory part rather than practical side. To the students of this background it is a problem to absorb the complex theoretical inputs but in practical session they are very good.

- Because of multifarious reasons many of the families could not start or engage in any of the self employment ventures, which is a main cause for their economic backwardness.

Setting of a Vocational Training Centre:

The ultimate aim of education is human refinement. Education should enable the learner to formulate a positive outlook towards life and to accept a stand which suits the well being of the society and the individual as well. The attitude and potential to work has determined the destiny, progress and cultural development of the human race. As we all are aware, the objective of education is to form a society and individuals having a positive work culture. The educational process expected in and outside our formal schools should concentrate upon inculcating concepts, abilities, attitudes and values in tune with these work culture. Hence vocationalised education cannot be isolated from the main stream of education. In another sense, every educational process should be vocationalised.

It is in the sense that the content and methodology of Vocational Education have to be approached. The need for meaningful linkages between the world of work and world of education is well recognized. The essence of the recommendations made by various commissions and committees is that the vocationalization should be the main feature of the future system of education at school level. Vocational education is a system of education which intends to prepare students for identified occupations, spanning several areas of activities.

This education imparts the life skills required by the youth to enter the world of work and assuming the responsibilities of adulthood. As per the expert meeting report (2001) of UNESCO, the life skills are grouped under 4 categories. They are;

1. Skills for personal fulfillment
2. Skills for living in society
3. Skills for dealing with changing economies
4. Skills for dealing with changing work patterns.

Objective of Vocational Education:

- To fulfill goals of development and the removal of unemployment and poverty.
- To provide 100% free education to at least 30% of the total beneficiaries (Free education will be provided to the beneficiaries from weaker sections of the society)
- To impart education relevant to increased production and productivity, economic development and individual prosperity.

- To make available skilled work force at all levels to alleviate the rural unemployment and for the development of nation.
- To develop environmental awareness to ensure sustainable development.
- To develop vocational aptitude, work culture, values and attitudes of the learners so as to enrich the productivity of the nation.
- To develop entrepreneurial competencies and skills of learners for self reliance and to undertake gainful self employment.
- To facilitate the expansion of higher education and explore future opportunities through innovative guidance and programs.
- To develop vocational competencies, creative thinking in the related areas and facilitate training.
- To acquire awareness about different job areas and to provide backgrounds for accruing higher level training in subjects concerned.

So in this context a well equipped vocational training centre will construct within the campus of the residential school. Vocational Education ensures fulfillment of manpower requirement or national development and for social security for the citizens through self-employment. It also helps to reduce the migration of rural youth to urban areas and thus helps in rural development.

The activities of the vocational training center:

We like to make the courses for the vocational training for the centers.

The Proposed Vocational Trade:

- X-Ray training
- Pathology Test
- Scanning Test
- Angiography etc.

Mobile Medical Van for the BPL People:

It is the right of every individual to keep up good health as weak and diseased people cannot make a healthy and strong nation. In order to enable its citizen good health, it is the moral responsibility of the government of the day to provide adequate health services to the people, especially the tribal poor and the disadvantaged who are most often than not are denied adequate health services. In the rural and inaccessible areas of Mayurbhanj District the public health services simply do not function regularly putting the people in great distress. The poor do not have money nor will to travel all the way to district hospital to avail of the services.

The Health Scenario in the State:

The poor economic condition of the state is well-documented in various reports released from time to time. Similarly the health statistics do not paint a rosy picture for the state. Almost half of the total malaria death occurs in Odisha, the state has an irrationally high Infant Mortality Rate and Maternal Mortality Rate; more than half of the women and children are anemic; half of the women and children are suffering from mal-nutrition. Apart from these ills the state of odisha suffers from various other diseases which are curable through some simple intervention.

The Area Problem:

There is no doubt that the health of the people, especially the poor is in a semblance. Every year Govt. has planned and invested huge money in health sector, but the services cannot reached to the target people. So inaccessible area people do not get health services in right time.

In the matter of health, sanitation and family welfare the proposed project area is quite backward. The knowledge regarding health and nutrition of the people is rudimentary. Due to superstition, isolation, negligence of health, lack of access to medical facilities and reliance on the traditional magic-religious method is the cause of their poor health and family planning. Due to poor sanitary condition, non-availability of portable drinking water, water diseases have reached endemic portions. The village people depend upon traditional faith healers and quacks for treatment which is most of the time is risky. Moreover there is no health and hygiene education nor propagation of small family norms in the block.

Hence there are no assured health services in the area and the PHCs are not able to serve more than 70% of people. In the absence of communication facilities, modern health care services are beyond their reach. Extension workers of health department do into visit the area regularly which results in non-immunization of at least 25% of the children below the age of 23 months. Diseases like T.B. rheumatism, epileptic and arthritic complaints, coughs and cold, dysentery, diarrhea and menstrual irregularities, gastroenteritis, ring/hook worm, leprosy etc. are more common in the proposed project area. Case of influenza, cough and cold is also very common the proposed project area.

Bad Habits and Related Health problems:

Consumption of alcohol and use of drugs and other kind of narcotics is very common among this community. This takes away major portion of the income and it causes many health problems and the treatment of the sickness again push them in to debt trap.

Health and Sanitation scenario is not sound:

- Change in life style is causing many diseases including Cancer, Heart problems, Diabetics etc.
- Poor sanitation and hygiene practices and facilities

- The traditional healing practices are in the stage of degeneration.
- The awareness and skill on health of the people especially in the changing situation is very poor.
- Diseases/ high cost for treatment drain away a major portion of the family's income.
- Food shortage/ food insecurity.
- Poor food intake and malnutrition.

Environment especially water scenario is on the degradation:

- Severe Drought/ scarcity of water
- Shortage of own source of drinking water and the women have to walk a long distance to fetch water.
- Water contamination
- Depletion of ground water table/ drying up of water sources during summer.
- Water born diseases
- Water and soil conservation practice has not been undertaken by the people
- Government machinery is not found effective in environment protection.
- Environmental pollution (Air, water etc.)

Some General Problems:

- Social Backwardness of the targeted community
- Poor functioning of the people's organizations already formed
- Poor self esteem
- Marginalized from mainstream developmental process
- Not organized for income generation programs
- Lack of awareness on developmental issues and programs
- Economic backwardness and indebtedness
- Poor Economic condition
- Degradation of traditional employment sectors

New skills are not gained to engage in other kinds of employment:

The Solution:

The people in the area do not seek medical advice for common illness which might snowball into major complications in the future. The reason for the people not availing of the public healthcare system is that either these are not giving efficient service or people do not travel long distances to avail of these services. Thus it is high time services were provided at door step to the people through mobile clinics.

Goal of the Project:

The goal of the project is to provide efficient and low-cost medical service at the door step of the poor and the disadvantaged.

Objectives of the Project:

- To reduce, control and eradicate diseases through mobile clinics covering the entire population of the proposed project area.
- To provide health care to the poor and needy at their door step.
- To provide health education to the people
- To immunize new born babies
- To conduct regular health check up camps and to advise the people relating the health matters.
- To motivate the people to adopt family planning methods for small family.
- To educate the people to live in a good sanitary condition and to advise them to use safe drinking water and to keep environment clean.
- To remove superstitions prevailing in the society regarding health care and treatment.

The area is afflicted by the following health problems:

- Lack of service by the public health institutions
- Lack of educations
- Lack of access to information regarding reproductive health
- Lack of pre-natal and post-natal care
- High inaccessibility
- Lack of regular medical check up
- High IMR and MMR
- Low couple protection rate
- Lack of health education
- Non-institutional delivery

- Myths and superstitions attached with pregnancy
- Prevalence of quacks
- Heavy physical labor by adolescent girls
- Lack of nutritious food
- Casual approach of the people to treat illness

Target Group:

Though the service will cover the entire population in the project area, the following category of people will be regarded as the special target group for the project.

- Senior citizens
- Family without any support
- Family with no sources of income
- Physically challenged
- Children
- Pregnant women
- SCs/STs/OBC/BPL

Action Plan:

Manner of Implementation:

In every village health committees will be formed which a village health guide will head. The village guide will selected from the village and will be given short term training about health and hygiene, usage of common medicines for common ailment; about dehydration and oral rehydration etc. she/he will play the role in motivating the people for family planning and use various methods for planning. She/he will intimate the project officials in case of serious ailments of any person so that the patient can be moved from the village to our hospital by the assistance of medical van, and its team for treatment. As far as transporting the patients is concerned special emphasis will be given for transportation of pregnant mothers and those needing urgent care. For this the Health Guides will be motivated to monitor the pregnant mothers so that they can be brought to the nearest health care centre for safe delivery.

Doctors, pharmacists and nurses appointed under the scheme will be visiting the adopted villages at regular intervals at least once in a week & make health check up of the patients & will provide medicines to the poor and needy patients. The social workers will be in-charge of the project villages for health education, sanitation, immunization and motivation for family planning etc.

Organization of Health Check Up Camps:

As mentioned earlier most part of the project area is difficult in terms of accessibility. As government health infrastructures are situated at long-distances people do not travel to avail of these services. Thus it is proposed to organize Health Check up camps in comparatively difficult and underserved areas. For convenience of the people the health camps will be organized at fixed time.

In short the following services will be provided by the mobile Medicare unit.

Activities:

- Simple curative service and first aid
- Prevention of communicable diseases
- Referral services
- Health check up
- Immunization
- Use of ORS
- Ante-natal care and post-natal care
- Maternal service
- Family planning
- Village health education etc.

Professionals:

The above activities will be done through mobile dispensary service. This unit will consist of one doctor, one staff nurse and a pharmacist with essential drugs and equipments. The primary task of the staff of the mobile unit is to look after the basic health condition done by this unit. The dispensary will be delivery point for basic curative and preventing health care and dispense medicines. This will be the referral service centre, control and treatment of common communicable diseases. Treatment of poor children, old and disperse, mother will be top priority of the mobile dispensary. Apart from the above highly skilled professionals one project coordinator will be appointed who will look after the entire management of project. Several volunteers will be appointed as Health Guides who will identify, inform and manage the project at the ground levels.

Expected Result:

- The project will achieve the following specific outputs.
- The rural people of the area will be provided with free Medicare services.
- Free health check up camps to all age group

- Free consultation and referred services.
- Cases of routine ailments will be decreased
- Decrease in MMR due to timely transportation of critical cases
- Increased awareness on health education by the poor

The Time Frame of the Project:

We are in touch with all sources right from purchase of land, contractors for construction as we get a green signal from donor we will start speedy construction and complete within one year.

From the beginning the Mobile Medical Van provide services to the targeted people and the second year there will be a kick start 30 bedded hospital and Nursing training, Vocational training ready to serve people.

Conclusion:

30 bedded Rural Hospital, Nursing training Vocational Training Centre and Mobile Medical Van will provide affordable accessible and available Health services for all specially for who are not aware regarding Health and not consider complications and faces other several health problems& create employment opportunities for unemployed youth of the area.

Monitoring & Evaluation:

- We are here going to implement a clear cut and transparent monitoring for the project
- Whole activities of the project will be monitored by the organization. Activities will be evaluated quarterly and report will be sent to Department of Revenue, Ministry of Finance Brief details regarding monitoring and evaluation process are as follows:-
- Keen observation of whole educational and administrative activities.
- Monthly progress and aptitude watch / test (pre and post project activities) of the beneficiaries.
- Weekly meeting of each program staff with the project Coordinator for review of the program.
- Monthly meeting of whole program staff with the project Director of the organization.
- Quarterly evaluation of whole activities.
- Monthly report of the monitoring will be completed with the help of weekly reports submitted by the supervisor to the project coordinator.

- Project coordinator will submit the complete monthly report to the project Director of the organization.
- On the basis of whole observation of the program, quarterly report will be finalized and the planning must go with the annual planning of the organization with the budget.
- The Management Information Systems (MIS) will be used as a mechanism to undertake monitoring
- The repot maintaining will be daily base and it can be verified at any time of its run.

There will be annual evaluation after first year of the project is over to assess the progress of the project and its strategies, and suggest necessary improvements in it. And, after completion of the project, a final evaluation will be done to measure the impact of the project and find out key learning.

-As Annexure X Budget

Sl. No.	Activity Description	1stYear budget			2nd Year budget			Total
		Total no of unit	Unit Cost (INR)	INR Total	Total no of unit	Unit Cost (INR)	INR Total	Unit Total INR
1	**Hospital Building and Accessories :**							
1.1	Construction of hospital, per square meter @ 7500 and the total square meter 5000	5000	7500	37500000	Do	Do	Do	3,7500,000
1.2	Fencing, Drainage, & water Supply.	1	1500000	1500000				15,00,000
1.3	Silent Generator 50 KV	1	600000	600000				6,00,000
1.4	Office Furniture			500000				5,00,000
1.5	Modern Mobile Medicare Van with full fill facility	1	9000000	9000000				90,00,000
1.6	Fire and safety			600000				5,00,000
	Total of Construction and implementation cost							**4,96,00000**

2	**ICU :**							
2.1	ICU Bed	4	40000	160000				1,60,000
2.2	Ventilator	4	200000	800000				8,00,000
2.4	Infusion Pump	5	20000	200000				1,00,000
2.6	Over Bed Table	5	6000	30000				30,000
2.7	Scrub Station (Stainless Steel)	1	50000	50000				50,000
2.8	Bed Site Locker	10	5000	50000				50,000
2.9	Emergency Resuscitation kit	5	10000	50000				50,000
2.10	Suction machine	2	5000	10000				10,000
								12,50,000
3.	**Other equipments :**							
3.1	Refract meter	1	100000	100000				1,00,000
3.2	Operating Microscope	1	200000	200000				2,00,000
3.3	Operating Table	2	30000	60000				60,000
3.4	Instruments	1	100000	100000				1,00,000
3.5	OT Light	1	50000	50000				50,000
3.6	USG Scanner	1	100000	100000				1,00,000
3.7	Spot Light	1	50000	50000				50,000
3.8	PTI Trolley	2	1500	3000				3,000
3.9	Scrub Station	1	150000	150000				1,50,000
3.10	Surgical Instruments	1	100000	100000				1,00,000
3.11	Suction machine	1	30000	30000				30000
3.12	ECG 12 level	1	100000	100000				1,00,000
3.13	CT Scan	1	150000	150000				1,50,000
	Total cost of ICU and the essential machineries							11,93,000

4	**Nursing College :**							
4.1	Construction of College-cum-Technical Training Centre, per square meter @ 7500 and the total square meter 2000	7500	2000	15000000				150,00,000
4.2	Fencing, Drainage, & water harvesting system.	1	1000000	1000000				10,00,000
4.3	Silent Generator 50 KV	1	600000	600000				6,00,000
4.4	Office & College Furniture			800000				8,00,000
4.5	Medical Stretchers-Pedigo General Transport Stretcher - 33.5" Wide	1	212300	212300				2,12,300
4.6	Pulse Oximeters (SpO2)	1	32725	32725				32,725
4.7	Surgical Tables	2	165000	330000				3,30,000
4.8	Exam Tables	2	35145	70290				70,290
4.9	Respiratory Ventilators	2	176000	352000				3,52,000
4.10	EKG Machines	1	86725	86725				86,725
4.11	Enteral Feeding Pumps	2	33220	66440				66,440
4.12	Infusion Pumps	2	109725	219450				2,19,450
4.13	Infant Care	2	45000	90000				90,000
4.14	Fetal Monitors	1	159500	159500				1,59,500
4.15	Anesthesia Equipment	1	1264945	1264945				1,26,4945
4.16	Defibrillators	1	94580	94580				94,580
4.17	Multi Parameter Monitors	2	178090	356180				3,56,180

4.18	Surgical Lights	1	103180	103180				1,03,180
4.19	Delivery Training Simulator	1	1924945	1924945				19,24,945
4.20	Nursing Simulator	2	41250	82500				82,500
4.21	Injuctable Arm For Training	2	33825	67650				67,650
4.22	Surgical Supplies	1	275000	275000				2,75,000
4.23	Anatomy Models For Nurse Training	2	15000	30000				30,000
4.24	Respiratory Therapy Supplies, Medical Monitoring Supplies, Intubation Supplies, EMS Supplies, Diagnostic Instruments, Cauvery Supplies & Electrosurgical Accessories, Anesthesia Supplies and other Nursing College Lab Equipments							15,00,000
4.25	X-Ray training Pathology Test Scanning Test Angiography & other testing equipments							1,50,00,000
	Total Nursing-cum-Med. Technical College Expenditure							**3,94,18,080**
	Total (1+4)- 3470000+850000+1183000+39418080							**9,44,48,080**
	B RECURRING COST							

5	**Project Personnel :**							
5.1	Project Manager (2)				12	30000	720000	7,20,000
5.2	Vocational Trainer(2)				12	25000	600000	6,00,000
5.2	Administrative officer (2)				12	25000	600000	6,00,000
5.3	Marketing manager (1)				12	25000	300000	3,00,000
5.4	Doctors Male (12)				144	50000	7200000	72,00,000
5.5	Doctors female (10)				120	50000	6000000	60,00,000
5.6	Compounder (5)				60	8000	480000	4,80,000
5.7	Nurses (10)				120	7000	840000	8,40,000
5.8	Nurses male (5)				60	7000	420000	4,20,000
5.9	Ward boy (4)				48	5000	240000	2,40,000
5.10	Technician (2)				24	6000	144000	1,44,000
5.11	Pharmacist (2)				24	5000	120000	1,20,000
5.12	Architect (1)	12	30000	360000			0	3,60,000
5.13	Account manager (1)	12	15000	180000	12	15000	180000	3,60,000
5.14	Accountants	12	15000	180000	12	17000	196000	3,84,000
5.15	Reception (1)				12	8000	96000	96,000
5.16	Office assistance (5)				60	5000	305000	3,05,000
5.17	Security (6)				72	5000	360000	3,60,000
5.18	Driver (3)				36	8000	288000	2,88,000
5.19	Housekeeping (2)				48	5000	240000	2,40,000
5.20	Staff welfare fund				1	300000	300000	3,00,000
5.21	Free food for the patients				12	100000	1200000	12,00,000
							Total of Project Personal Cost	**2,16,29,000**
	Non Recurring Cost+ Recurring Cost (94448080+2,16,29,000)							**11,60,77,080**

6	**Other Recurring Cost :**							
6.3	Overhead expenses @2%						1020941	10,20,941
6.4	Consultancy fee @2.5%						1276177	12,76,177
6.7	Audit, monitoring and documentation						200000	2,00,000
							Total of the other cost	**24,97,118**
	Grant Total-11,60,77,080+24,97,118/-							
	Estimated budget for the Two years = 11,85,64,198/-							

Grant Requested from the Ministry of Finance is Rupees Eleven Cores Eighty Five Lakhs Sixty Four Thousand One Hundred Ninety Eight only.

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