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Maharashtra Arogya Mandal's -Project review

About the institute

The Maharashtra Arogya Mandal, Hadapsar, Pune, is a **Non Governmental organization** (NGO) and **Registered Charitable Trust** established on **11th June 1960** by the late **Dr Dadasaheb Gujar** and his colleagues with the aim to provide better health care facilities to the poor and underprivileged classes of society.

Aims and objectives

- **To create awareness amongst people for social & economical upliftment.**
- **To educate people about health care, sanitation & the advantages of small family.**
- **To take care of parentless and destitute children who are neglected, undernourished and seek resources to grow into rightful citizens.**
- **To provide training and credit facilities for self employment.**
- **To build up a community of villages by providing equal rights to women on the firm pillars of justice, equality, love and educate people to eradicate social evils such as dowry, untouchability etc.**
- **To enhance livelihood conditions of tribal community by creating avenues for increasing income based on local resources.**

Functional Areas

- **Medical / Health**
- **Education**
- **Rural & Tribal Development.**

There are 15 different Institutes functioning under the roof of MAM in the above 3 main areas. An Ayurvedic Medical College with a 200 bedded hospital with all faculties was started in the Hadapsar area of Pune city.

Sane Guruji Arogya Kendra (Hospital) **Functioning since 11th June 1960** **Bed Strength – 200**

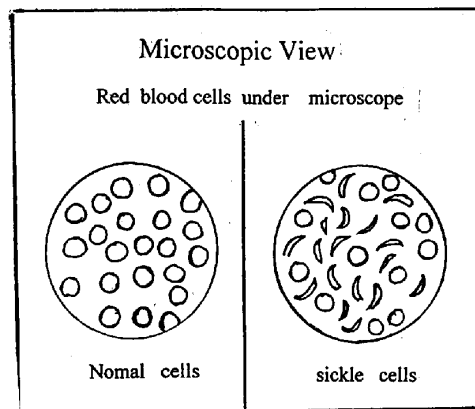
Facilities available in the Hospital

- Gynecology & Obstetrics Dept.
- Pediatric unit with Neonatal I.C.U.
- Mother & Child Welfare Unit
- Full fledged Operation Theatre
- Complex Pathology Laboratory.
- Well equipped Physiotherapy Unit, Radiology & Imaging Dept.
- Special Ayurved O.P.D. & Panchkarma Center
- State of Art I.C.U..

In addition to this, several health projects catering to the needs of tribal people in rural areas were also developed and clinics established in such areas. **The Sickle Cell Anemia Project is such a project that started in 1998 with a mandate to provide diagnosis, treatment, counseling and prevention.**

About Sickle cell Anaemia Project

Sickle cell anemia is a hereditary defect confined to red blood cells. The basic defect is in the structure of hemoglobin molecule of the red blood cells. These cells acquired sickle like shape in oxygen deficient environment. Due to this effect there is early destruction of the cells leading to condition known as sickle cell anemia. The sickle cell disorder is a public health problem and most common amongst the scheduled castes (SC), scheduled tribes (ST), nomadic tribes (NT) and other backward classes (OBC) from the state of Maharashtra.



The individual with sickle cell anaemia has common symptoms

- **Moderate to severe Anaemia**
- **Mild Jaundice**
- **Severe joint pains**
- **Dyspnoea(Difficulty in breathing)**

This symptom begins at early age (3 to 4 years) and severity of symptoms increases with age. Patient has painful and limited life span. In addition to these symptoms one of the typical symptom experienced by majority of the patients is known as **Sickle Cell Crisis**. Whenever there is increase demand for oxygen in the body i.e. during infections, heavy physical exercise, exposed **to extreme cold or hot summer** or excess fluid loss, the **Sickling process gets accelerated**. The stickled red cells entangle with each other and may cause obstruction. When blood flows through micro capillaries, the obstruction may stop further blood supply developing ischemic condition and causes tremendous pain at that site.

The frequency, period, intensity of crisis varies from individual to individual. When, where, how crisis develop is difficult to predict. Pain remains for few minutes or few hours or few days. During crisis, pain is unbearable and pain killer drugs have limited effect. **Patient cannot bear the pain and are helpless. Parents cannot bear patient's painful condition. Ultimately whole family get disturbed, worried and scarred about episode.**

It is observed that patients have less immunity and hence more susceptible for common infections. With the chronic illness and repeated episodes of crisis every organ of the body is likely to be affected, **including brain with stroke (paralysis), the lungs**

with respiratory failure, the kidney with renal failure and Avascular necrosis of bones. The long-term studies emerge out following observations.

- **It injures every organ of the body but does not affect everyone in the same way.**
- **Differ in both extent of complications and severity from individual to individual.**

Treatment:

No curable treatment is available at present. Techniques like Bone Marrow Transplantation, (BMT) Gene therapy, and Hydroxyl Urea treatment are very costly and not affordable to people in whom this is public health problem. No curable treatment is available. **Proper premarital Counseling and prevention of new sickle cell baby birth is the only major mode to tackle this problem.**

Genetics of Sickle Cell Hemoglobin

In a population the defect occurs in two forms, one **heterozygous state** (suggesting defect on only one chromosome of the pair) and another **homozygous state** (suggesting defect of both chromosome of the pair). Heterozygote individual usually do not suffer from any symptoms of the disease and hence known as **carrier** and homozygote individual always remain ill and known as **sufferer**. In depth studies of sickle cell defect suggest following guidelines.

- **The parents of sufferer baby are always carrier or sufferer.**
- **To a carrier parents the chance to have sufferer baby at each pregnancy is 25% carrier baby 50% and baby without sickle cell defect is 25%.**
- **In affected population the ratio of sufferer to carrier is 1:20**

Background

In 1972, a team of Russian Anthropologists visited India with the aim to study genetic markers amongst tribal population groups from Maharashtra and selected the Pawara tribal groups from Sahada taluka of the Dhule district. Prof. S.L.Kate was selected as a member from the BJ Medical College and given the responsibility of studying different blood genetic markers. While screening the Pawara tribal community for blood markers, he came across with few heterozygous and one homozygous patient suffering from sickle cell anemia. This was a new and first finding from Uttar Maharashtra area. He presented his data to his mentor Prof G S Mutalik who suggested him to continue this project work. He continued with work on this project and screened few more tribal groups from different tribal areas along with non-tribal population groups from the state of Maharashtra.

Prof. Kate retired from the Govt. Medical College in 1993 and continued to work on this problem as an emeritus medical scientist of the Indian Council of Medical Research (ICMR). The ICMR was planning to establish a temporary sickle cell anemia diagnosis and counseling centre in tribal areas of Maharashtra in order to find out the acceptability of tribal people for marriage counseling program. Two centers were established, one at **Dhadgaon Taluka of the Nandurbar district** and the other at the Aheri Taluka of Gadchiroli District under the supervision **of Dr S.L. Kate**. ICMR was unable to continue with this activity for several reasons and **the identified patients were left without any treatment and counseling.**

On this background, Prof. Kate approached Dr Dadasaheb Gujar, Secretary of the Maharashtra Arogya Mandal, Hadapsar Pune, and explained to him the need of the tribal people.

Why Maharashtra Arogya Mandal accepted this proposal-

Newly created Nandurbar district of the Maharashtra state was part of Dhule district. The separation of this part of Dhule district is on the basis that majority (66%) of the population from this part belongs to tribal population group & it should be possible to promote welfare schemes for tribal people on priority basis.

The district is located on the extreme north part of the state on border line with neighboring states Gujarat & Madhya Pradesh. The district consists of six talukas as **Nawapur, Nandurbar, Shahada, Taloda and Akkalkuwa & Dhadgaon**. 75% of the population belongs to **Scheduled tribes, Scheduled caste & other backwards communities**. Out of this 66% of the population belongs to two major groups known as **Bill and Pawara**.

Since these groups are isolated, scattered, living in geographically hilly areas, existing health facilities are inadequate and unable to co-up with their health needs. & hence remain backward in all aspect of life including health and education. They are poor and backward and hence under influence of superstitions, particularly towards health problems.

The health problem amongst S.T., S.C. & OBC population from these areas have been studied by Maharashtra Arogya Mandal Pune Which are as follows.

- | | |
|--|---|
| ➤ Malnutrition | ➤ Alcohol consumption and Superstitions |
| ➤ Water borne and communicable diseases | ➤ Extreme poverty |
| ➤ Sickle Cell Anaemia, Thalassemia(Genetic Disorders) | ➤ Poor and inadequate health facilities |

Rationale of selection Dhadgaon Taluka for our community control programme.

- Difficult hilly terrain located between third, fourth, and fifth and sixth ranges of Satpuda with 96% population belong to tribal population groups.
- Tribal population remains backward, isolated from rest of the district.
- For any developmental projects (including health), it is difficult to approach and hence medical facilities (including preventive) are inadequate and poor in qualities.
- Sickle cell disease is one of the public health problems in this area. **Even no diagnostic facilities are available in Govt. institution and in Pvt. Health Sector leave aside the treatment.**

Maharashtra Arogya Mandal, Hadapsar Pune has vast experience of working in tribal areas, expertise knowledge about genetic disorder prevalent in tribal areas, devoted team of medical and non medical personnel and willing to work in tribal areas, hence Maharashtra Arogya Mandal has decide to work on Sickle Cell Anemia Problem and to begin with established center at Roshmal BK, Dhadgaon taluka with the plan to extent these activities in another talukas of the district. Looking at our efforts a social local tribal man Mr. **Bhimsingh Pawra and his son Mr. Manoj Pawra decided to donate his land for the construction of Sickle Cell Dawakhana.**

We are working in this taluka since 1997 and we screened 25 villages for sickle cell disorder and other health problems. We found high prevalence for nutritional anemia and sickle cell anemia. We have mobile laboratory and facilities for blood investigations. We have conducted population screenings programme in 20 villages from this Taluka for sickle cell disorder.

It was noticed that even though Sickle cell anemia is public health problem, people as well as medical practitioner working in these areas have no idea about sickle cell disease.

On the basis of data collected by our team the rough estimation for sickle cell disorder is as follows.

Prevalence with Screened Data

Total population of Nandurbar Dist.	> 15,00,000
Expected carrier (22.5%)	> 3,37,500
Expected sufferer (1%)	> 15,000
Total population Screened	105900
Carrier (22.5%)	23979
Sufferer (1% approx)	1108

Dr. Kate and his team of Maharashtra Arogya Mandal have been working in this district for last several years and found that 22%of the tribal people are carrier for the disorder and1% people are sufferer. With his experience **Maharashtra Arogya Mandal established the center in Dhadgaon taluka in Dec.1998 and made arrangement to provide following facilities.**

- Diagnostic facilities for sickle cell disorder.
- Treatment and follow-up of patients.
- Population genetic screening program to detect carriers and sufferers.
- Health education
- Marriage counseling
- Genetic counseling
- Training facilities.

We follow Ayurvedic system and provide Ayurvedic medicine .We found one of the drug prepared by pharmacy of our institution is effective. There is improvement in anemic condition (Maintains blood hemoglobin level), intensity of crisis is decreased and duration and recurrence of the crisis is prolonged. On the basis of our experience we have developed a **sickle cell medical kit** which consists of a polyherbal medicine called **SC3, Folic Acid, Soda mint and Painkillers like Paracetamol. This kit is distributed free of cost. Also hot water bags, Blankets, Umbrella Warm clothing are distributed free to prevent the episode of crisis and to improve the quality of life. We have also conducted sonography camps.**

Patients and parents are happy with our medical and social treatment .Now we have **1108 patients** diagnosed out of which **600-700** are under regular medical supervision. **Reason for of irregular follow up is migration for labour in adjoining states and negligence towards this health problem.** Every time our old patient brings new patient from his/her village.

At present we organize our health camps once in two months and by finding out responses of the patients, planning to visit every month. We provide treatment free of cost.

The project area is a hilly terrain area in 3rd and 4th ranges of Satpuda. The distance from Pune is more than 550 K.M. We have appointed a **Medical Social Worker and Doctor for clinical supervision, guidance and communication with the patient about the camp and the benefits of treatment is conveyed in local language by medical social worker and volunteers.**



**Dr. Dadashaeb alias S.T. Gujar (Founder MAM and Sickle cell project), Mrs.Gujar (Sitting)
Dr. Graham Sergeant Dr. Beryl Sergeant, Dr.S.L.Kate (From Left Standing) International Scientist in field
of Sickle Cell Disease**

Screening and Treatment Camp on road side tree (1996)



Our Dreams come True (2001)

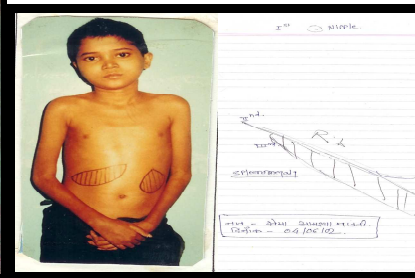


Patients Waiting for Screening and Treatment



Clinical Examination

Patient with Liver & Spleen enlargement





Laboratory investigations Electrophoresis and solubility Test



Sonography conducted in Project area



Distribution of Sickle Cell follows up note book, Hot water Bags,



Sickle cell screening camp



Distribution of Hot water Bags, Umbrellas by Mr. Arun Gujar



Senior Pediatrician Dr. Dhairyasheel Shirole with Sickle Cell Team

BHIMASHANKAR TRIBAL DEVELOPMENT PROJECT Since Sept 1981

Not resting on the relative prosperity brought to nearby villages of Hadapsar, MAM shifted its focus of development to the tribal people in the Ambegaon, Junnar and Khed blocks of Pune District.

The area is inhabited by the tribal Mahadeo-Koli. The area receives about 4000 to 6000 mm of rainfall and the height is about 1000 to 1100 meters above mean sea level. **Though it receives heavy rainfall during rainy season i.e. June to September, in summer, drinking water becomes a severe problem.**

The area was heavily forested. During 1962-65 a road leading to Bhimashankar temple was built. The road contractor became a coal contractor soon afterwards and the jungle was completely chopped off. The forest department did not care at all. The poor people did not understand the implications. The whole area presents a sad picture of barren hill slopes, even in the interior parts. The coal contractor became a rich man at the cost of national loss. The Government people blame the tribals, for having sold trees on their owned lands ignoring their own responsibilities for protection of Govt forests. The jungles that are saved as yet are the temple forests dedicated to the Tribal Gods. **It is known as Deorai.**

The people residing in the interior area though agriculturists depend heavily on forest produce for their livelihood. The main forest produce is myrobalan (Hirada) this is a fruit also called as *Terminalia chebula*. It is used in Ayurvedic medicines as well as in tanning industry.

In old days the merchants used to buy Hirada from tribals at a very cheap rates or in barter system, exploiting them very much. **Now it is under monopoly purchase scheme of Maharashtra Government.**

We started to work in this area in 1981 with pre-primary schools with support of OXFAM. We also organized agitation against the low prices of Hirada fruits. We also started to tackle the problem of severe drinking water scarcity in summer under the **'Water for health Programme'** funded by CAPART, Govt. of India, progressing from drilling of bore wells / handpumps and then with a kind help from **Arbeiterwohlfahrt** to village ponds.

We started working in three villages in 1981. Up-till now we worked in **211** hamlets with various programmes and are in good contact with many other hamlets.

Out of 44 villages in the catchment's area of Dimbha Dam, 11 were completely submerged in Dimbha dam lake. The best land of another 13 villages has been submerged under the lake water. Approach to all interior villages became very difficult due to the stored water of the dam lake. In all **1254** tribal families were displaced as their lands submerged in dam water.

Government did rehabilitation of these displaced families. However nearly 60% displaced families returned back from places where they had been rehabilitated by Govt. and settled at their old land, which is above the submergence level. In these villages facilities for education, health, electricity and bus transport etc. are extremely poor. During rainy season, heavy rains and fast flowing streams cut-off most of the area from any forms of vehicular transport.

Socio Economic and Geographical Situation of the Project:

- Scattered hamlets of 10-20 houses each, 1-3 Km from each other. Hamlets generally connected by steep, precarious footpaths.

- Transport of harvest from field to home by head-load only. Bullock carts almost non-existent. Landless persons very few.
- As most of the land is hilly, barren, unfit for cultivation, large land holdings also does not imply a well to do family.
- Education -one-teacher, 2-4 classes in single room schools generally do not work properly. Illiteracy among women is very high.
- Medical facilities extremely scarce. Drinking water is a serious problem in summer. No public transport in half of the area.
- Government services - very poor. Programs, facilities etc which hardly reach most of the population.

Problems of livelihood insecurity in the area:

- Rain fed agriculture and lack of irrigation facilities. Soil erosion and land use pattern (shifting cultivation) Low returns from the agriculture. Rapid deforestation
- Absence of local bodies to manage the resources
- Prevailing money lending system and economic crises
- Migration for supplementing the low income from agriculture

Since year 1981, MAM has been implementing following activities to overcome the above problems.

- Awareness creation and building knowledge and skills on the aspects related to natural resource management & livelihood.
- Formation of village institution/ users groups and its strengthening. viz- Village Development Committee, Food Grain Bank, Self Help Group, NTFP Societies etc. Creation of village development fund.
- Natural Resource Dev. through land, water, vegetation & live stock development. Promotion of sustainable agricultural practices like-Vermi composting.
- Economic development through incentive for chick and goat rearing, micro entrepreneurship, grain banks.
- Improvement in health, hygiene and sanitation through health care activities, kitchen gardening, soak pits etc. Promotion of improved cooking devices.

The overall programme approach and strategy is having focus on Participation, empowerment, sustainability and self-reliance. Our main thrust is on beneficiary's contribution and participation and we are proud to say that **the beneficiary contribution in all the activities is 45%.**

Achievements :

✓ VDC Formation	61
✓ SHG Formation	176
✓ Water Ponds	106

✓ Bench Terracing (Padkai)-in Ha	888
✓ Continuous Control Trench in Ha	1127
✓ Plantation	9263
✓ Grain Bank	76
✓ Health & Hygiene & Sanitation Camp	22
✓ Trainings	148
✓ Check Dam	7
✓ Gabion Structure	42
✓ Loose Bolder Structure	5573
✓ Farm Pond	19
✓ Community Lift	3
✓ Farm and Stone Bund Ha	113
✓ Vermin Compost	329
✓ Smokeless Chula	153
✓ Renovation of Schools	40
✓ Coaching Classes (in hamlets) 933Students	52/month
✓ Kitchen Garden	4526
✓ NTFP	4
✓ Water Filter	913
✓ Paraprofessional Trainings	22
✓ Soak Pits	124
✓ Medical Kit	155
✓ Integrated Crop Management ha	32
✓ DEWAT plants	1
✓ Fodder Management	45
✓ Compost Pit	10
✓ Improved Cooking Devices	357
✓ Shared wells	10
✓ Bio Gas	150
✓ Total hamlets covered under the programme	207

Indo-German Watershed Development Project :

Background of The Project :



Naiphad & Kharoshi-Awhat watershed is located in Khed block of Pune district on Khed-Bhorgiri road at a distance of 46 km, from the taluka headquarter. The total coverage of watershed area is about 3107.01 ha, Bhimashankar Range falls in humid zone, in high rainfall region of Sahyadris- Western Ghat region. Topography of the area is undulating and eroded. The top altitude surface of the land is totally desiccated with less vegetation, on account of rapid felling of trees and intensified grazing added to the problems of excessive runoff and soil erosion.

The watershed project area receives an average annual rainfall of 2180.22 mm. but there is acute scarcity of drinking as well as irrigation water throughout the year and also adversely affects harvest, which results in acute shortage of food and fodder. Almost all of the families from the Bhimashankar Range are socio-economically



backwards. They have in uplands, but most of which is undulating and situated on heavy slope terrain of the range. They are generally cultivating their cultivable dry land by extending their faith on "God". Also most of the tribal families from villages of the Bhimashankar range are constrained to migrate towards near by urban areas, such as Manchar, Narayangaon, Pune, kalyan and Mumbai etc. to meet their need for sustenance. This

rapidly degrading ecology of the watershed can be arrested and also regenerated by a planned comprehensive watershed development programme. Which comprising of not only vegetative and mechanical measures but also self-motivated active participation of the people to achieve and sustain the development!

Criteria For Selecting Village :

The identified site of the project should be -

- Well-defined watersheds with the village boundaries coinciding to the greatest extent possible with the watershed boundary. The area of watershed should be a manageable unit.
- The site of the watershed should be with noticeable erosion and depletion of natural resources such as soil, water and vegetation. Scarcity of water for drinking as well as agricultural purpose.

- Hilly mountainous area, having serious problem of sustention followed by migration of the residents for source of income. Predominantly poor village.
- High proportion of Schedule Caste and Schedule Tribes community.
- Village with a known history of coming together for common causes.
- Village that have shown concern for resource conservation.

Project Strategy :

The degraded ecological cycle needs to be restored with a well-managed **Comprehensive Watershed Development Programme** as under:

- Awareness among the people about ecological degradation as well as participatory solution of watershed management for all the problems. To make it a people's program by organizing them for collective decision-making and implementation.
- Treatment to the entire watershed with sustainable soil and water conservation measures applying **Ridge to valley Principle** aimed at reducing soil loss and maximizing the availability of water.
- Land utilization according to its capability to support the cropping pattern.
- Reducing stresses on available resources such as **Land, Water** and **Vegetation** by encouraging allied income generating activities like dairy, poultry, goatry (Stall feed) and tiny agro-based industries.
- Building up infrastructure for credit availability, processing and marketing, so that the producers get the maximum benefit to the efforts instituted by them.
- Formation and strengthening of the village based people's organization for collective decision-making and action.

Objectives :

General Objectives:

To undertake sustainable development of natural resources through restoration of ecological balance in the watershed and to improve their standard of living as well as life.

Specific Objectives:

- To organize the community in different groups/ local institutions and their capacity building.
- To strengthen available natural resource base such as land, water and vegetation for increasing their productivity.
- To regenerate the ecology by increasing vegetative covers for drought proofing.
- To create a sustainable livelihood opportunities for men and women equally.
- To increase the earning capacity of people in order to improve their socio-economical status and avoid their migration from rural to urban.
- To increase the availability of biomass for crop productivity.
- To insure local employment opportunities.
- To avoid silting of the ponds and reservoirs.
- To enable the people to manage and maintain their assets.

Achievements :

* Continuous Control Trench	2510.03
* Check Dam	17
* Gabion Structure	4

Impact :

- a) Availability of drinking water in summer months also and women are utilizing their saved time for productive work.
- b) As a result of additional land brought under cultivation, villagers are getting enough farm produce to last for the whole family round the year and hence under nourishment amongst children is almost over in the villages where bench-terracing activity implemented.
- c) Control over soil erosion and conservation of water, which helped moisture retention for paddy crop survival during dry spell. 120 families getting two crops annually by irrigation through shared wells.
- d) Enhancement in self-image of women and their status in the family as they started earning by goat/ chick rearing and self help group support.
- e) Due to availability of credit facility within the village people are escaped from moneylender's trap. Food security through bench terracing and food grain banks.
- f) Control over school dropouts and enhancement of educational standard of school children. Availability of Primary Health Services at doorsteps.
- g) Building of reading habits among tribals and tribals are getting information regularly.
- h) Tribal are getting fare prices for their Non Timber Forest Produces. Control over temporary migration.
- i) Increase in farm produce through availability of vermin compost.

MAM has been carrying all these tribal development activities and programs with valuable support from **AWO-International, Germany**. MAM and tribal community from the project area are thankful for their generous and kind financial support.

Golden Jubilee Celebration Function of Maharashtra Arogya Mandal

Maharashtra Arogya Mandal is a charitable trust established on 11th June 1960, registered under BPT Act 1860. MAM is running 15 institutions under Health, Education and Rural / Tribal development. MAM has celebrated 2010 as Golden Jubilee year and organized various programs. MAM has completed Golden Jubilee year with the presence of **Honorable President of India Mrs. Pratibha Patil on 11th Oct. 2010 in Balgandharva Rangmandir, Pune.**



For this function honorable Transport Minister – Mr. Radhakrishna Vikhe Patil, Maharashtra State Governor-Mr. K. Sankaranarayanan, President of India – Mrs. Pratibha Patil, Forest Minister – Mr. Patangrao Kadam, Pune Mayor – Mr. Mohansingh Rajpal was the dignitaries for our function.



MAM President Dr. S.F. Patil and MAM Secretary Mr. A.S. Gujar have felicitated and gave memento to the President of India Honorable Mrs. Pratibha Patil and also Dr. S.F. Patil shared MAM's work and felicitated other dignitaries also.



Unveiling of Plaque for renaming of MAM's Primary, Secondary and Higher Secondary School at the hands of Maharashtra State Governor Mr. K. Sankaranarayanan.



Maharashtra Arogya Mandal's Souvenir and Biography on founder member of MAM, Late Dr. Dada Gujar, publication at the hand of Governor and first copy presented to Honorable President.



Honorable President Mrs. Pratibha Patil has expressed her views about MAM.

“Non Govt. organizations to play a key role in ensuring the welfare of the downtrodden in the society and Maharashtra Arogya Mandal are doing very good work in social field”. The President lauded the services rendered by MAM and said more and more NGO's should emulate the work done by MAM. Also she hailed the contribution of the MAM and recalled the untiring efforts of

Dada Gujar (founder member of MAM) and Mr. G.P Pradhan (sir).

MAM Achievement

- Dr. Dada Gujar was awarded “Hadapsar Bhushan” for the year 2002, at the auspicious hands of Retd. High Curt Judge Mr. Chandrashekar Dharmadhikari
- Dr. Dada Gujar was awarded “Sane Guruji Jivan Ninstha Purskar” for the year 2003 by Sane Guruji Sahitya Sanskruti Sangam, Jalgaon.
- Dr. Dada Gujar was awarded “ Indian Merchant Chambers Platinum Jubilee Endowment Award” by the Indian Merchant Chambers Platinum Jubilee Endowment trust for family panning work.
- Dr. Dada Gujar was awarded “Meri Zukaj” award form AWO International, Germany. (first time this award given to individual out of Germany)
- Dr, Dada Gujar was awarded “Bapu Puraskar” by Mahatma Gandhi Smruti Purskar/Trust, Pune
- Pimpri Chinchwad Municipal Corporation felicitated and honored with Manpatra to Dr. Dada Gujar for his help and guidance in establishment of Lokmanya Hospital.
- Dr. Dada Gujar was awarded “Pune’s Pride” for the year1998 by Residency Club.
- 132 squint operations were performed in a day at Sane Guruji Arogya Kendra which is recorded in Limca Book of Records (an Indian version of Guineas book of records)

MAM has below new projects for serving people in better manner: -

- Construct hostel building for Muktangan Tribal Girls Hostel
- Expand watershed work, strengthening Capacity Building Groups in Bhimashankar Tribal area, Pune district.
- Expansion of Ayurved Pharmacy
- Expansion in Ayurved Research
- Research & Expansion of Sickle Cell Anemia disease (Dist. Nandurbar, Tribal Area)
- Expansion of Sane Guruji Arogya Kendra from 200 bedded hospital to 300 beds.

We need support for –

Every two months for the Sickle Cell diagnostic and treatment camps 10-12 Medical and paramedical Staff along with Laboratory equipments, Generator, Medicines have to travel continuously for 14 hours and more. The vehicle we are using is more than 15 years old and it is insufficient. **Thus we require support to sponsor a Vehicle for this humanitarian project.**

Man Power-

We need additional man power for counseling programme.

Medical Doctor- 1

Medical Social Worker-1

Medical Laboratory Technician-1

These staff members will be on contract basis for five years, till we get permanent staff. We require financial support to maintain the project staff.

The Activists are putting their full time for community development and the people donating their savings for such community work. These are the pillars of any voluntary organization. **We are thankful to the Donors and funding organizations for their trust through financial support.**

Thanking you

Yours Truly

ANIL GUJAR

Secretary

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ESTIMATED BUDGET FOR SICKLE CELL PROJECT

Budget for Sickle Cell Project		
Particular	Recurring (Annual)	Nonrecurring
Ambulance		1500000
Jeep		900000
Digital Camera (for documentation purpose)		20000
Traveling Expenses 20,000 x 6 Visits	120000	
Maintenance of Vehicle and fuel 15,000 x 6 Visits	90000	
Laboratory Chemicals	15000	
Stationary for printing, Documentation and IEC Programme	15000	
Medical Officer (2) Remuneration	600000	
Medical Social Worker (2) Remuneration	240000	
Medical laboratory Technician Remuneration(2)	240000	
Laboratory Attendant remuneration(2)	168000	
Medicine Cost 15000 x 6 Visits	90000	
Clerk Cum Accountant	108000	
Driver	96000	
Total	1782000	2420000
Grand Total (A+B)	4202000	
Contingency (A+B) 10 %	420200	
Total Budget	46,22,200/-	

Total : - Forty six Lac twenty two thousand two hundred Rs. Only