Donation asked Rs. 1834.01 Crores

PROJECT PROPOSAL

ON

BHARTI MEDICAL COLLAGE AND HOSPITAL

MULTI FACILITY HOSPITAL

IN

GADHMOHNI, P.O-GOPALPUR, GOGRI, DIST-KHAGARIA-851203 (BIHAR)

SUBMITTED BY

BHARTI SEWA SADAN TRUST

AT- SHIVPURI, WARD No.9, DIST-ARARIA, BIHAR

PROJECT PROFILE

PROJECT HEALTH

EDUCATION

Tittle of the Proposed Programme :

'Health Education'-A delayed reorganization of **Potential.**

Area of Operation:

All over in Bihar, India

Total 100 Nos. of centres setup.

Project Period : 5 (Five) Years.

Detailed Programme of the Course will be followed a set pattern. A brief outline is as the followings:- Health Awareness Generation Programme consists of the following activities through IEC Method to increase the KAP level of the target groups.

1. Prevention of Aids
2. Stop TB Programme
3. Malaria
4. Family Planning & Population Education
5. Iodine Deficiency Disorder Control
6. Reproductive Child Health
7. Blind Control & Deficiency of Vit-A
8. Immunization
9. Water Awareness & Sanitation
10. STD & other communicable diseases
11. Prevention& Cure of Stress factor
12. Prevention of Health Diseases
13. Yoga & Naturopathy
14. Disease caused by Industrial Hazards
15. Proper use of Industrial & Pesticide

Semister-I

D Existing status of health and nutrition of mother and child in the block, talk by a resource person from the block.

D Participants to be speak on their personal experience of health & hygiene condition of the proposed project area as well as their respective communities, their problems and achievements.

D Mental Nutrition- Its importance in relation to infant, nutrition.

D Dietary requirements of the adolescent girl.

D Dietary requirements of the pregnant mother.

D Dietary requirements of the lactating mothers.

D Some common misconceptions related to maternal nutrition and how to deal with them.

Semister-II

D Infant Nutrition (1)

D Malnutrition and specific deficiency disorders prevalent in district.

D Under nutrition.

D Growth monitoring as an important tool for preventing under nutrition, use of the growth card.

Semister-III

D Infant Nutrition (2)

D Breast feeding and all messages related to

D Impotance of exclusive breast feeding for first 4 to 6 months.

D Harmful effects of bottle feeding.

D Supplementary feeding.

D Importance of starting by 6 months.

D What and how to feed as the baby grows.

D Some common misconceptions related to infant feeding and how to deal with them.

Semister-IV

Child Survival Strategies :-

D Low birth weight babies.

D Immunization.

D Diarrhoea management and oral rehydration.

D Personal and environmental sanitation.

Semister-V

Communication media and Skills:-

D Discussion on training materials and methods to be used in the proposed project area.

D Person to person contact taught by role play presentations.

Semister-VI

D Recapitulation.

D Action plans to be formulated and presented by the participants and finalized with the help of Institution team and resources.

All the above mentioned seminar session will be conducted or coordinated by the organisation team. Resource persons will also be invited to speak in areas of specialization from our respective district. Group participants will be encouraged. Talk will be supplemented with flow charts, flash cards, slides and video tapes by a resource person in the local language. Wherever possible, representatives from states Health &Family Welfare Bureau UNICEF, ICDS will be invited as resource, persons.

Relevance and importance of the course in the content of the present day National needs. :-

Introduction

The objectives of health education are well summarized in the report of the first expert committee on health education that met in Geneva way back in 1953. It emphasized that-

"That aim of health education is to help people to achieve health by their own actions and efforts. Health education begins therefore, with the interest of people in improving their conditions of living and aims at developing a sense of responsibility for their own health betterment as individuals and as members of families, communities or governments."

Health education is not a new concept. Folklore on health has existed for centuries, passed down informally from generation to generation. However the formalization of health education came only with the introduction of western systems of medicine. That health education was recognized as a vital component of the health care delivery system is reflected in India's First Five-year Plan. The initial step in providing preventive, primitive and curative health care to the rural populace was taken with the establishment of primary health centres as health posts, of the major functions attributed to these centre health education was one.

Health Education for Health Action

During the 1970's a new understanding of health education and health care emerged. For the first time, debates on the differences between 'Health Care' & 'Medical Care' were taking place and the limits of 'Hospital based' & 'Doctor Centred' health care in improving the health status of people were being recognized. Several non-governmental initiatives in alternatives health care under dynamic and charismatic leaders were initiated. The significant changes in health care were possible with strategies and approaches based on "Äwareness building", 'conscientization' & 'empowerment' and not merely 'Information dissmination'.

It was also recognized that maintaining good health & preventing disease depends to a large extent on the way people live and the manner in which they use material resources and health service. Many of our health problems are due to improper health practices, illiteracy, poverty, inaccessibility and unavailability of health service serve to compound the problem. One fact, however, that emerges is the positive changes in health related behaviour have come about only educational masseges and strategies have taken into account the link between the cause of ill-health and socio-context.

COMMUNICATION

It is generally accepted that the most effective and appropriate communication strategies and the messages that need to be disseminated can only be decided after taking into account the cultural attitudes and behaviour patterns of the community. As cultural determines the educational methods that are acceptable and comprehensible to people, it also determines the methods to which people will respond. Communication are framed after determining the best message and the most appropriate media to influence the intended audience.

UTILIZATION OF HEALTH CARE SERVICES

Despite the efforts of the government and various programmes which aim to prove the health status and quality of life of the underprivileged populations like the scheduled tribes and scheduled casts and below poverty line backward groups, the utilization of health service is reported to be very poor. There is no significant change in the important indices of health like infant mortality, maternal mortality and incidence of communicable diseases. This situation calls for a very close and detailed analysis of the influence of special socio-cultural and economic conditions on the health behaviour of these groups.

STATEMENT OF PROBLEM ON INFANT FEEDING PRACTICES

Of the numerous problems facing India's development, malnutrition is the most dominant. The term malnourishment, implies imperfect nourishment occurring when the demands of the body for certain nutrients are not met (under nutrition), or are met in excess (over nutrition). Malnutrition has been for many years a grave and widespread problem of our country. The cycle of under-nutrition and infection is responsible for high mortality and morbidity amongst children. In facts being more vulnerable, suffer the most. The reasons for under nutrition apart from poverty are faulty feeding practices and ignorance. Thus a successful promotion of whole some and hygienic feeding practices will reduce infant mortality to some extent.

WOMEN & NUTRITIONAL STATUS

Several micro-studies have shown that diets of female children and women are inadequate as a result of discrimination in intra-household food allocation. Discrimination begins during infancy with breast feeding, when infant girls receive less milk, less frequently and for shorter periods than boys. They are also weaned earlier, thus predisposing them to malnutrition. Studies have shown that the problem continues through childhood and adolescence, in time of food scarcity, women's access to food is further circumscribed. Females are also discriminated against in terms of the equality of food available to them. As a consequence, girl fail to achieve full growth potential. Such women are at risk from obstructed complications and give birth to low birth weight babies.

SITUATION ANALYSIS

So far in the medical/ health scenario of West Bengal, various studies have shown that there are three major areas that require serious attention-

→ Decline of the age old traditional and healthy practice of breast feeding Which services as a life saver apart From being the only natural food and drink for the infant's first 4 to 6 months of life. This practice is slowly but surely being eroded by the unethical aggressive marketing practices of baby food manufacturers. The devastating effect of bottle feeding on infant morbidity and mortality particularly among poorer rural and urban sections of society are well documented.

→ Another cause for concern is the practice of late initiation of supple mentary feeding, well beyond 6 months of age, which is often the starting point of under nutrition. Due to ignorance, poorer mothers do not initiate food from the kitchen, they rather look for some special food for infants.

→ Surprisingly, the health functionaries and people who are responsible for health counselling and also found lacking in the newer knowledge of healthy feeding practices for mother and children.

CONCLUSION

In essence, attainment of adequate nutrition levels for economists, sociologists, psychologists, anthropologists, demographers, agricultural scientists, communication specialists and all agencies concerned with food production, transportation, storage and distribution. Nutrition must be seen as synonymous with overall socio-economic development.

WHY THE COURSE-ITS RELEVANCE

The proposed course will act as inter active plateform for educating the students/participants in health education through dissemination of information. No. of inventions which are the outcome of decade long research in our Medical Institutions and Medical Research Stations will be propagated through transfer of Medical Technology. The participants will be progressive villegers, medical profession, community leaders members of voluntary sectors, the representatives of Block Medical Officer of Health. The resource persons will be from Medical Institution, Professional Doctors, Medical Officers and other Hospital based Doctor. The subject of discussion will be choose according to the local need of villagers (who are the participants only) and present infection diseases, applicable with respect to the local social condition and of course it will be simultaneously children and young adults needed to be exposed to better understanding of in fact feeding practices.

To facilities such a dispersal effect, the organization, along is to a identify nucleus villages (at least one Gram Panchayat), from where further effects could be channelized and coordinated.

Efforts is to be made to reach the mothers by various village level or Block level health and other interested NGOs by establishing linkage with home science colleges, consumer groups, teacher, students and medical profession.

Objective of the Medical related Course

The objective of the course is to improve child health and nutrition by-

- Orienting the organisation staff and other voluntary workers to the importance of Improved Infant Feeding Practices by collecting and disseminating information on Improved Infant Feeding Practices.
- Educating mothers and raising awareness among future parents regarding importance of breast feeding and better hygiene and cleanliness in the handling and feeding of infants.
- Disseminating updated information to members of medical profession on breast feeding and Infant Feeding Practices.
- Persuading the manufacturers to follow the Indian National Code for the Protection and Promotion of breast feeding as a policy, by Highlighting the importance of Improved Infant Feeding Practices.

ACTIVITIES:-

The main activities of the course will be planned as under-

1. Identification of villagers at each Gram Panchayat and initiate dialogue with institution.
2. To be collected of baseline information from villagers on knowledge, attitude and practices regarding Infant Feeding, including breast feeding, supplementary feeding and the infrastructure available for reaching the mothers regarding Infant Feeding Practice.
3. To be identified an institution at Block level (resource group) which would be willing to conduct the baseline survey as well as final survey in the village based project area.

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HEALTH CARE SERVICE IN INDIA

Healthcare in India features a universal health care system run by the constituent States and territories of India. The Constituent charges every state with "rising of the Level of nutrition and the standard of living of its people and the improvement of public Health as among its primary duties". The nation health policy was endorsed by the parliament of India in 1983 and updated in 2002. However the government sector is underfinanced; poor services at state-run hospitals force many people to visit private medical practitioners.

Government hospitals, some of which are among the best hospitals in India, provide treatment at taxpayer expenses. Most essential drugs are offered free of charge in these hospitals. Government hospitals provide treatment either free or at minimum charges. For example, an outpatient card at AIIMS (one of the best hospitals in India) costs a onetime fee of rupees 10 (around 20 cents US) and thereafter outpatient medical advice is free. In hospital treatment costs depend on financial condition of the patient and facilities utilized by him but are usually much less than the private sector. For instance, a patient is waived treatment costs if he is below poverty line. Another patient may seek for an air-conditioned room if he is willing to pay extra for it. The charges for basic in hospital treatment and investigations are much less compared to the private sector. The cost for these subsidies comes from annual allocations from the central and state government.

Primary health care is provided by city and district hospitals and rural primary health centre (PHCs). These hospitals provide treatment free of cost. Primary care is focused on immunization, prevention of malnutrition, pregnancy, child birth, postnatal care, and treatment of common illnesses. Patients who receive specialized care or have complicated illnesses are referred to secondary (often located in district and taluk headquarters) and tertiary care hospitals (located in district and state headquarters are those that are teaching hospitals).

In recent times, India has eradicated mass famines; however the country still suffers from high levels of malnutrition and disease especially in rural areas. Water supply and sanitation in India is also a major issue in the country and many Indians in rural areas lack access to proper sanitation facilities and safe drinking water. However, at the same time, India's health care system also includes entities that meet or exceed international quality standards. The medical tourism business in India has been growing in recent effective medical treatment at lower costs than in developed countries.

HEALTHCARE INFRASTRUCTURE IN INDIA

The Indian healthcare industry is seen to be growing at a rapid pace and is expected to become a US$280 billion industry by 2020. The Indian healthcare market was estimated at US$35 billion in 2007 and is expected to reach over US$70 billion by 2012 and US$145 billion by 2017. According to the investment Commission of India healthcare sector has experienced phenomenal growth of 12 percent per annum in the last 4 years. Rising income levels and a growing elderly population are all factors that are driving this growth. In addition, changing demographics, disease profiles and the shift from chronic to lifestyle diseases in the country was led to increase spending on healthcare delivery.

Even so, the vast majority of the country suffers from a poor standard of healthcare Infrastructure which has not kept up with the growing economy. Despite having centers of excellence in healthcare delivery, these facilities are limited and are inadequate in meeting the current healthcare demands. Nearly one million Indians die every year due to inadequate healthcare facilities and 700 million people have no access to specialist care and 80% of specialists live in urban areas.

In order to meet manpower shortages and reach world standards India would require investments of up to $20 billion over the next 5 years. Forty percent of the primary health centers in India are understaffed. According to W.H.O. statistics there are over 250 medical colleges in the modern system of medicine and over 400 in the Indian system of medicine and homeopathy (ISM&H). India produces over 25000 doctors annually in the modern system of

medicine and a similar number or ISM&H practitioners, nurses and Para professionals. Better policy regulations and the establishment of public private partnerships are possible solution to the problem of manpower shortage.

India faces a huge need gap in terms of availability of number of hospital beds per 1000 population. With a world average of 3.96 hospitals beds per 1000 populations India stands just a little over 0.7 hospitals beds per 1000 population. Moreover, India faces a shortage of doctors, nurses and Paramedical that are needed to propel the growing healthcare industry. India is now looking at establishing academic medical centers (AMCs) for the delivery of higher quality care with leading examples of The Manipal Group & All India Institute of Medical Sciences (AIIMS) already in place.

As incomes rise and the number of available financing options in terms of health insurance policies increase, consumers become more and more engaged in making informed decisions about their health and are well aware of the costs associated with those decisions. In order to remain competitive, healthcare providers are now not only looking at improving operational efficiency but are also looking at ways of enhancing patient experience overall.

India has approximately 60000 allopathic doctors registered to practice medicine. This number however, is higher than the actual number practicing because it includes Doctors who have emigrated to other countries as well as doctors who have died. India licenses 18000 new doctors a year.

CENTRAL GOVERNMENT'S ROLE

Critics say that the national policy lacks specific measures to achieve broad stated goals. Particular problems include the failure to integrate health services with wider economics and social development, the lack of nutritional support and sanitation, and the poor Participatory involvement at the local level.

Central government efforts at influencing public health have focused on the five-year plans, on coordinated planning with the states, and on sponsoring major health programs. Government expenditures are jointly shared by the central and state governments. Goals and strategies are set through central-state government consultations of the Central Council of Health and Family Welfare. Central government efforts are administered by the Ministry of Health and Family Welfare, which provides both administrative and technical services and manages medical education. States provides public services and health education.

The 1983 National Health Policy is committed to providing health services to all by 2000. In 1983 health care expenditures varied greatly among the states and union Territories, from Rs 13 per capita in Bihar to Rs 60 per capita in Himachal Pradesh, and Indian per capita expenditure was low when compared with other Asian countries outside of South Asia. Although government health care spending progressively grew throughout the 1980s, such spending as a percentage of the gross national product (GNP) remained fairly constant. In the meantime, health care spending as a share of total government spending decreased. During the same period, private-sector spending on health care was about 1.5 times as much as government spending.

PRIMARY SERVICE

Health care facilities and personnel increased substantially between the early 1950s and early 1980s, but because of fast population growth, the number of licensed medical Practitioners per 10000 individuals had fallen by the late 1980s to three per 10000 from the 1981 level of four per 10000. In 1991 there were approximately ten hospital beds per 10000 individuals. For comparison, in China there are 1.4 doctors per 1000 people.

Primary health centers are the cornerstone of the rural health care system. By 1991, India had about 22400 primary health centers, 11200 hospitals, and 27400 clinics. These facilities are part of a tiered health care

system that funnels more difficult cases into urban hospitals while attempting to provide routine medical care to the vast majority in the countryside. Primary health centers and sub centers rely on trained Paramedics to meet most of their needs. The main problems affecting the success of primary health centers are the predominance of clinical and curative concerns over the intended emphasis on preventive work and the reluctance of staff to work in rural areas. In addition, the integration of health services with family planning programs often causes the local population to perceive the primary health centers as hostile to their traditional.

Preference for large families. Therefore, Primary health centers often play an adversarial role in local efforts to implement national health Policies.

According to data provided in 1989 by the Ministry of Health and Family Welfare, the total number of civilian hospitals for all states and union territories combined was 10,15. In 1991 there was a total of 811,00 hospital and health care facilities beds. The geographical distribution of hospitals varied according to local socio-economic conditions. In India's most Populous state, Uttar Pradesh, with a 1991. In Kerala with a 1991 population of 29 million occupying an area only one –seventh the size of Uttar Pradesh, there were 2053 hospital.

Although central government has set al goal of health care for all by 2000. Hospital are distributed unevenly. Private studies of India's total number of hospitals in the early 1990s were more conservative than official Indian data, estimating that in 1992 there were 7300 hospitals. Of this total, nearly 4000 were 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 are medical equipment 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% 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 emergency of the new concept in India of establishment hospitals and health care facilities on a for- profit basic.

By the late 1980s, there were approximately 128 medical college- roughly three times more than in 1950. These medicals colleges in 1987 accepted a combined annual class of 14,166 students. Data for 1987 show that there were 320,000 registered medical practitioners and 219,300 registered nurses. Various studies have shown that in both urban and rural areas people preferred to pay and seek the more sophisticated services provided by private physicians rather than use free treatment at public health centres.

TRADITIONAL PRACTICES

Indigenous or traditional medical practitioners continue to practice throughout the country. The two main forms of traditional medicine practiced are the ayurvedic system, which deals with mental and spiritual as well as physical well-being, and the unani (or Galenic) herbal medical practice. A vaidya is a practitioner of the ayurvedic tradition, and an hakim is a practitioner of the unani or Greek tradition. These professions are frequently hereditary. A variety of institutions offer training in indigenous medical practice. Only in the late 1970s did official health policy refer to any form of integration between European – trained medical personnel and indigenous medical practitioners. In the early 1990s there were ninety-eight ayurvedic college and seventeen unani college operating in both the government and non-governmental sectors.

HEALTH INSURANCE

The majority of the Indian population is unable to access high quality healthcare provided by private as a result of high costs. Many are now looking towards insurance companies for providing alternative financing options so that they too may seek better quality health care. The opportunity remains huge for insurance providers entering into the Indian healthcare market since 750/0 of expenditure on health care in India is still being met by out of pocket consumers. Even though only 10% of the Indian population today has health insurance coverage, this industry is expected to face tremendous growth over the next few years as a result of several private players that have entered into the market. Health insurance coverage among urban middle and upper-class 3 Indians, however, is significantly higher and stands at approximately 50 %.

The insurance Regulatory and development Authority (IRDA) is the governing body Responsible for promoting insurance business and introducing insurance regulations in India. The share of public sector companies in health insurance premiums was 760th and that of private sector companies was 240 / 0 for the period 2005-06. Health insurance premiums collected over 2005-06 registered a growth of 35yo over the previous year. In 2001 the IRDA introduced provisions for Third Party Administrators (TPAs) to support the administration and management of health insurance products offered by insurance companies. TPAs are facilitators in the coordination process between the health insurance provider and the hospital . currently there are 27 TPAs registered under the IRDA.

Health insurance has a way of increasing accessibility to quality healthcare delivery especially for private healthcare providers for whom high cost remains a barrier.[in order to encourage foreign health insurers to enter the Indian market the government has recently proposed to recently proposed to raise the foreign direct investment (FDI) limit in insurance from 26/0 to 490k. Increasing health insurance penetration and ensuring affordable premium rates are necessary to drive the health insurance market in India.

CO- OPERATIVE MOVEMENT IN HEALTHCARE

Role of co- operative system is very limited in India in contrast to Profit oriented private sector. Although there had been some co – operative medical services providers in Kerala which are facing severe decline over the period due inability to serve voluntarily and better options in urban areas.

MEDICAL EQUIPMENT LIST FOR TYPICAL DISTRICT HOSPITAL

Hospital building cost (number of floors as per availability of land)	730,20,00,000.00
Campus Development	12,00,00,000.00
Total Campus and Building maintenance contract (5 years)	8,00,00,000.00
Cardiology Setup	1,70,00,000.00
Cardio logical cath . Lab	2,10,00,000.00
Surgical unit setup (including 2 O.T.)	10,10,00,000.00
Special Diagnostic tab & Radio therapy) with blood bank	50,00,00,000.00
Orthopeares setup	63,00,000.00
Ophthalmology set up	82,00,000.00
Mammography devices set up	2,44,00,000.00
USG Device Set up	2,49,00.000.00
Microscopy and colposcopy sets	8,66,00.000.00
Computerization	365,00.000.00
Nephrology	90,00,000.00
Oncology set up	1,70,00,000.00
Pathological Laboratory set up	190,00,000.00

Aids control unit set up	5,00,00,000.00
Obstetrics & child care	2,50,00,000.00
Herbal medicine centre	3,75,00,000.00
Ambulance (5)	135,00,000.00
Generator (9)	19,50,000.00
X – RAY Equipment's	2,15,20,000.00
Laboratory Equipment's	1,15,25,000.00
Theatre Equipment's	75,80,000.00
ICU Equipment's	1,10,00,000.00
Pharmacy Equipment's	1,75,00,0000.00
EYE UNIT Equipment's	1,75,80,000.00
ENT Equipment's	1,50,00,000.00
DENTAL UNIT Equipment's	22,51,00,000.00
Minor Theatre Equipment's	85,55,000.00
CASUALTY Equipment's	10,50,25,000.00
Minor Theatre Equipment's	2,25,10,000.00
WARD Equipment's & Development	125,75,80,000.00
MATERNITY Equipment's	10,25,75,000.00
Theatre, maternity	125,10,80,000.00
PHSYSIOTHERAPY Equipment's	110,25,20,000.00
OCCUPATIONAL THERAPY Equipment's	125,40,50,000.00
ORTHOPAEDIC TECHNOLOGY EQUIPMENTs	5,25,90,000.00
Sterilization Equipment	3,25,00,000.00
Furniture, Beds, Utensils, Computer, Telephone etc.	8,25,00,000.00
Transport Vehicles (3)	41,00,000.00

Inflation in the cost of Building material (15%)	109,53,00,0000.00
Total	1520,80,40,000.00

Note :- the cost of the building will very the size of the land. However, the target is to accommodates all the above mentioned facilities in the hospital.

Recurring Expenses For Multi- facility Hospital

Designation/ Particular	Remuneration/ Month/ Head Rs	Total No.	Expenses/ Year Rs
Health Superintendent	80,000.00	20	1,92,00,000.00
Health Supervisor	25,000.00	30	90,00,000.00
Health Assistant	20,000.00	45	108,00,000.00
Physiotherapist	25,000.00	15	45,00,000.00
Trained Nurses	16,000.00	100	192,00,000.00
Consultants Doctors	35,000.00	25	105,00,000.00
Store Keeper	7,500.00	50	45,00,000.00
Sweeper	7,500.00	25	22,50,000.00
Electricity Charges	5,50,000.00*12		66,00,000.00
Diesel for Generator	1,00,000.00*12		12,00,000.00
Canteen Expenses	5,00,000.00*12		60,00,000.00
Accountant	15,000.00	5	9,00,000.00
Lab Technician	20,000.00	10	24,00.000.00
Radiology /Technician	20,000.00	10	24,00.000.00
OT Assistant	20,000.00	10	24,00.000.00
Blood Collection staff Peon	20,000.00	10	24,00.000.00
Pharmacist	20,000.00	10	24,00.000.00
Ward Boy	20,000.00	10	24,00.000.00
Dietary cost for patients	20,000.00	10	24,00.000.00
Dietician	20,000.00	10	24,00.000.00
Reagents for laboratory	20,000.00	10	24,00.000.00
Security Guard	17,000.00	50	102,00,000.00
Miscellaneous			50,25,00,000.00
Total			60,73,50,000.00
Recurring Expenses for Five Years			303,67,50,000.00

RECURRING COST OF THE PROJECT OFFICE

Description	Remuneration/ Head	Total No.	Expenses/ month	Expense / year
Project Director	**2,25,000.00**	**2**	**12**	**54,00,000.00**
Health Director	**1,50,000.00**	**1**	**12**	**18,00,000.00**
Project co- ordinator	**1,25,000.00**	**2**	**12**	**30,00,000.00**
Chief Accounting (CA)	**2,25,000.00**	**2**	**12**	**60,00,000.00**
Chief Dietician	**75,000.00**	**2**	**12**	**18,00,000.00**
Office Clerk	**45,000.00**	**2**	**12**	**10,80,000.00**
Total at Heat Office per Year				**1,90,80,000.00**
Total Cost for five Year				**9,54,00,000.00**

Total Budget For the Project

1520,80,40,000.00+303,67,50,000.00+9,54,00,000.00=

Rs. 1834,01,90,000.00