နယ်လှည့်ကျောင်းအိတ်ကျန်းမာရေးလုပ်သားအဖွဲ့
Back Pack Health Worker Team
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I. PROPOSAL SUMMARY

Project Title: The provision of primary health care among Internally Displaced people and vulnerable population of Burma.

Project Programs: Medical Care Program
Community Health Promotion and Prevention Program
Maternal and Child Health Program
Health information and documentation, capacity building and monitoring and evaluation are integrated within these three programs

Target Population: 180,000 people living within the Mon, Karenni, Kayah, Karen, Shan, Lahu, Pa O and Arakan areas

Project Duration: January to December 2008

Budget Required: 30,558,250 Thai baht

Organisation: Back Pack Health Worker Team
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PROPOSAL CONTENTS

II. BRIEF BACKGROUND

(i) Overview[1]

Burma is a Buddhist nation of around 52 million people. Though abundant in natural resources, it is one of the world's poorest nations, receiving UN Least Developed Country status in 1987. The people of Burma belong to over 100 ethnic groups: the largest group are the Burmans, followed by Shan, Karen, Arakan, Mon and Kachin. Nearly half the population is under 18 years of age and over 70 percent of people reside in rural areas.

For 45 years, Burma has been ruled by a brutal military government that maintains a culture of fear and perpetrates widespread human rights abuses against its own people. Corruption, economic mismanagement, exploitation of vast natural resources, poor governance and enforced isolation of the people, are also hallmarks of the State Peace and Development Council (SPDC), the current junta.

Health has not been a high priority for the SPDC, demonstrated by Burma's overall health system performance ranked as the second worst in the world. Whilst Burma spends over 40 percent of the national budget on the military, it spends less than 3 percent on health. Many preventable diseases are rampant in the general population. Immunization programs have not been successfully implemented in rural Burma due to military restrictions preventing access to border areas. Cross-border programs from Thailand are unable to deliver immunisation due to the lack of cold chain for the safe transport of immunisations.

(ii) Civil War and Burmese Government Policy[2]

For decades, civil war has been waged in Burma to restore democracy and resolve the rights of ethnic minorities. Divisions between ethnic groups escalated during World War II; with the majority Burmans supporting Japan and the Axis powers; whilst some ethnic groups such as the Karen, remained steadfast to the British. Extensive abuses were perpetrated on the pro-British groups by the Burmese army, during and after the war. By 1962, when Ne Win staged the first military coup, many ethnic minority groups were in armed rebellion.

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[1] BPHWT, *Chronic Emergency: Health and Human Rights in Eastern Burma*, September 2006; Eric Stover, Voravit Suwanvanichkij, Andrew Moss, David Tuller, Thomas J Lee, Emily Whichard, Rachel Shigekane, Chris Beyrer, David Scott Mathieson, *The Gathering Storm: Infectious Diseases and Human Rights in Burma*, Human Rights Centre, University of California, Berkeley and Centre for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health, July 2007.

[2] BPHWT; Eric Stover et al.

In the mid 1960s, the junta embarked on the *four cuts* policy, designed to cut food, funds, intelligence and recruits to insurgent groups, provided by their families and local villagers. Utilising military campaigns and cease-fire deals with some insurgent leaders, the Burmese military government has solidified its control of the country. To date, 17 armed groups have accepted cease-fire deals with the junta.

By 1997, the Burmese military government had introduced a policy of self-sufficiency for regional commands operating along Burma's frontiers. This meant military units required an economic base and in developing this; they increased arbitrary taxation for villagers, confiscated villager's land and property, and increased the demands for forced labour on military projects. This has contributed to the further impoverishment of villagers in rural Burma, especially villagers of ethnic minority descent.

(iii) Human Rights Abuses

People flee their villages to hide in temporary shelters in the jungle - 2007

Returning to the village can be deadly, as landmines are laid by the Burmese soldiers - 2007

Promoting fear through state propaganda; public punitive threats and actions; jailing political opponents; arbitrarily detaining and torturing its citizens; preventing citizens from associating freely or having contact with the external world; are regular hallmarks of the junta. In border areas where armed ethnic groups are active, the SPDC forces villagers to relocate with no compensation for houses, personal belongings, livestock or crops left behind. Then the SPDC confiscates anything of value, destroys infrastructure and crops, and lays landmines to prevent villagers from returning. Within areas under the control of ethnic opposition groups, the policy is more brutal. Marauding Burmese soldiers raid villages, shooting people on sight, raping women, burning village infrastructure and food stores. People flee into the jungle to hide in temporary shelters, taking what little they can carry.

Forced labour - Toungoo 2006

Villagers flee the abusive Burmese soldiers and seek shelter in the jungle - 2007

HUMAN RIGHTS ABUSES IN BPHWT FIELD AREAS

During 2004, BPHWT surveyed their target population and found that during the previous 12 months, of the households surveyed:

- **Nearly one third had suffered forced labour**
- **Almost 10 per cent had been forcibly displaced**
- **A quarter had their food confiscated or destroyed**
- **Nearly one in 50 had suffered from soldier perpetrated violence**
- **One out of 140, had a member injured by a landmine**

MALARIA WITHIN POPULATIONS IN BPHWT FIELD AREAS

- **BPHWT uses Paracheck, a rapid field diagnostic test, to diagnose malaria**
- **Over 12 per cent of the population at any given time is infected with *Plasmodium falciparum*, the most dangerous form of malaria**
- **Malaria accounts for almost half the deaths of adults and children within the BPHWT operational area**
- **Forced relocation and fleeing to the jungle, without mosquito nets and access to appropriate and timely care, increases the risk of acquiring malaria and dying as a result** (BPHWT 2006)

(iv) Internally Displaced Persons (IDPs)

There are estimated to be between 600,000 and one million people internally displaced in Burma, hiding from the oppressive tactics of the Burmese soldiers.

The continuous demand for forced labour by military commanders, impacts heavily on the villagers' ability to farm to provide for their own precarious needs. Women and children are not excluded from forced labour which takes many forms. Being compelled to carry supplies for Burmese soldiers on the front line of armed conflict, is the most feared and dangerous form of forced labour.

(v) Health of IDPs and People Living in Rural Remote area of Burma

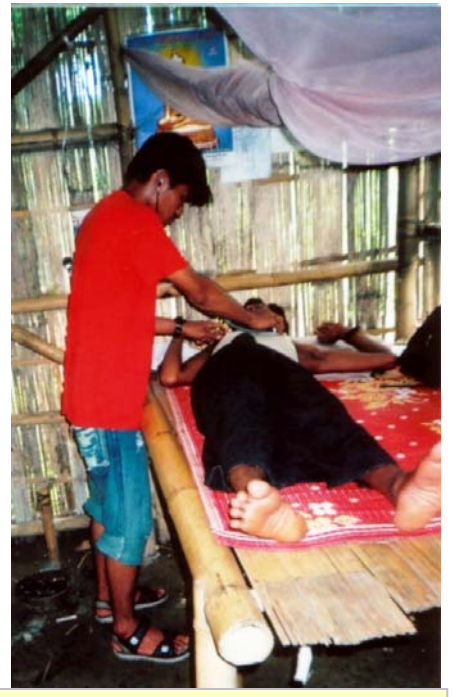
While the health of the population of Burma is poor, the health of IDPs and people living in remote communities deep inside Burma is a national tragedy. These people not who not only face harsh living conditions in which they struggle to survive and feed themselves; they are unable to pay the required fees to access Burmese health programs, if they are available. People report that if they are unable to pay, they are denied access to SPDC health services.In this harsh political environment, some humanitarian health assistance is being provided to these people, by non-government and community based organizations, coordinated in Thailand. BPHWT receives international funding and works collaboratively within field areas, to deliver health care.

(vi) Current Situation in BPHWT Field Areas

In 2007, Field-in-Charges continued to report on the deteriorating conditions within their fields. Increased military activity and armed conflict; higher demands for forced labour; greater confiscation and destruction of property; increased forced relocation; and higher SPDC taxes and prices of essential goods were reported. As a result of these conditions, more people have fled from their villages. In Papun, 500 families have left their villages and remain hiding in the jungle. More villagers have fled from Toungoo where armed conflict has been intense and trekked to the Thai-Burma border, where a second IDP camp providing shelter to around 400 people has been established on the Burmese side of the Salween River. The first IDP camp now provides shelter to nearly 4,000 people.

Field-in-Charges once again reported they had insufficient medical supplies to treat the high number of sick people. Unfortunately, three backpacks of medicine and TBA kits were stolen by the SPDC in Kawkareik. More fields (Kayah, Kayan, Toungoo and Thaton) returned timely data in the first half of 2007, reflected in the 39,456 reported cases treated in the first half of 2007, compared with 23,826 reported in the same time period of 2006. Some data were also returned in the recently implemented Shan and Lahu fields. BPHWT fields reported treating 78 gunshot injuries, including three children less than five years of age; and 14 landmine injuries, one in a child under five years.

Field reports continue to detail the stresses and dangers BPHWT Health Workers face whilst delivering health care in the fields. To date in 2007, three Health Workers have been arrested, two in Mergue/Tavoy and one in Thaton. The current situation within the BPHWT fields contributes significantly to mental health stresses reported by many BPHWT Health Workers, Traditional Birth Attendants (TBAs) and Village Health Volunteers (VHVs).

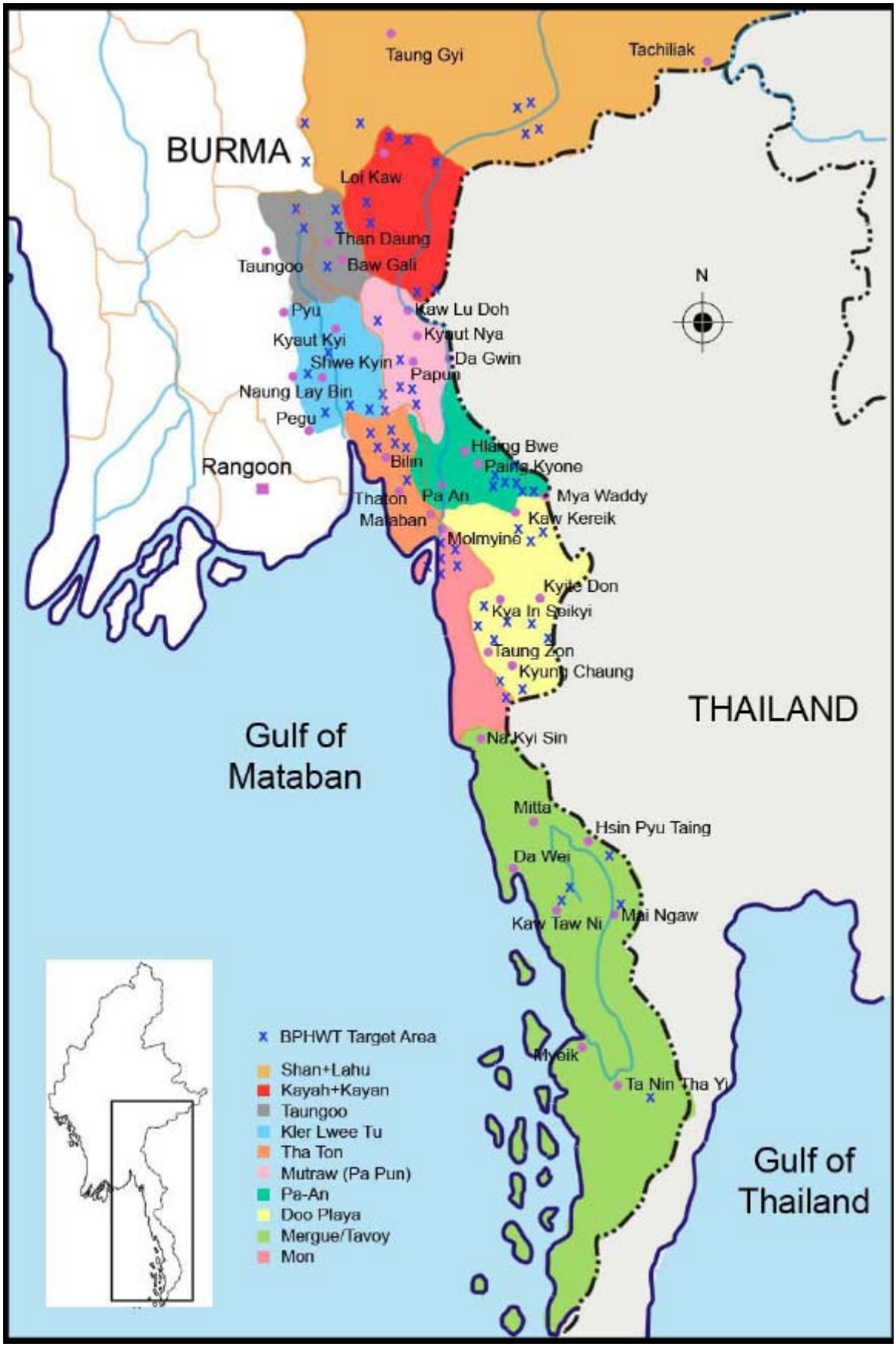


Delivering health care in Arakan State - 2007

III. THE BPHWT TARGET POPULATION

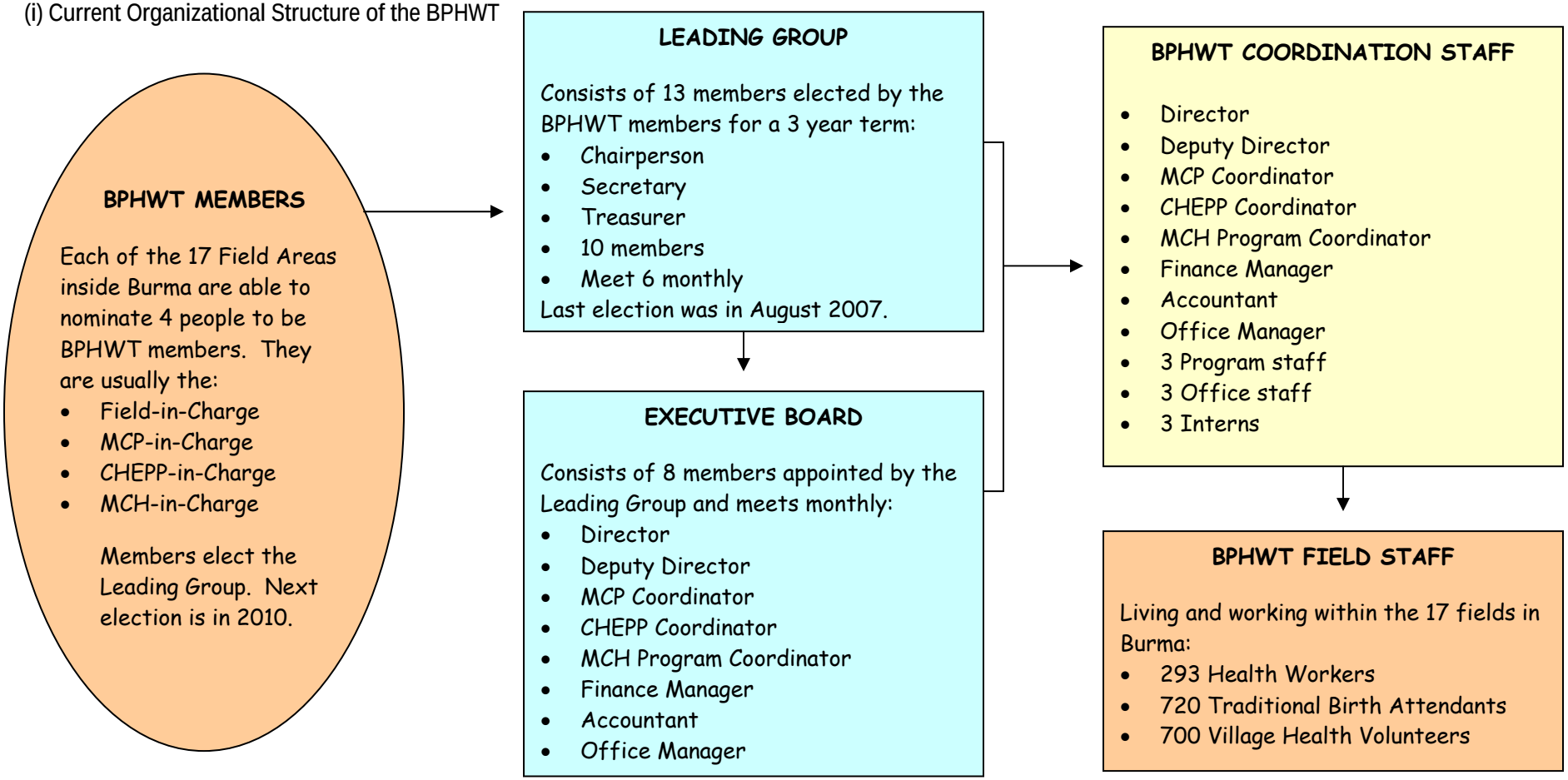
In 2007, the BPHWT target population was around 160,000 vulnerable people, either internally displaced or living in remote villages with no access to health care. During 2007 four additional BPHWT teams were implemented in the newly established Shan and Lahu fields. The Lahu field is in the north of the area located on the following map and is under the direct control of the SPDC, which has a cease-fire agreement with the Shan State Army-Northern (SSA-N); whilst the Shan field is in the south of the area and the Shan State Army-Southern (SSA-S) is involved in active resistance with the SPDC. In 2007, the BPHWT also implemented a pilot program and conducted a needs assessment in the two potential fields of Arakan and Pa O. The health of the BPHWT target population is extremely poor, hence the BPHWT is committed to extending the target population to include a further 14,000 people, through the development of the Arakan and Pa O fields and the implementation of more teams in other areas of need.

IV THE CURRENT BPHWT TARGET AREA



V. BACK PACK HEALTH WORKER TEAM

(i) Current Organizational Structure of the BPHWT



(ii) Governance

As depicted in the Organizational Structure, the BPHWT is governed by the Leading Group which is elected by BPHWT members. The 13 member Leading Group appoints an 8 member Executive Board, which meets monthly to make operational decisions for the implementation and coordination of the BPHWT programs. The BPHWT has a range of policies that guide the leadership; management; health care delivery; human resources; health information systems; capacity building; and monitoring and evaluation within the organization. Full copies of these documents are available upon request.

THE BPHWT CONSTITUTION

The Constitution provides the framework for the operation of the BPHWT through thirteen Articles that define the organization's name, vision, mission statement, organizational identification, symbol, goals, objectives, policies and principles, actions and implementation, monitoring and evaluation, membership, election of the leading group, amendments to constitution and organizational restructuring, employment of consultants and job descriptions for positions. Amendment of the Constitution of the BPHWT requires support from 75 percent of Leading Group members, and the amendments are required to be confirmed at the next six monthly BPHWT Meeting.

VISION

For a healthy society in Burma, through the primary health care approach to the various ethnic nationalities and those communities in the remote interior areas of Burma.

MISSION

To equip people with the skills and abilities necessary to manage and address their own health problems, while working towards long-term sustainable development.

GOAL

To reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary health care.

FINANCIAL MANAGEMENT AND ACCOUNTABILITY

The BPHWT has written finance policies and procedures guiding the Leading Group, Executive Board, Coordination and Field Staff about financial management and accountability; the production of annual financial reports; and the requirement for an annual, independent audit. These documents establish the financial records to be kept; the management of bank accounts; the procedures for cash withdrawals, deposits, transfers, receipts, disbursements and general administration funds; and liquidation of cash assets. There are also regulations for payments for board, lodging, travel and honorariums for services rendered.

(iii) Gender Policy and Analysis

Sixty percent of the people working within the BPHWT are women. However, the organisation has a gender policy which aims to improve equity for women across all levels of the organisation. Table 1, depicts the current targets and actual percentage of women across organisational tiers. To date, the BPHWT meet only the targets set for Field Management and Health Workers, though these targets do not reflect equality of access for women. Field Workers are required to travel the field to deliver health care. Many mothers are unwilling to leave their children at home with carers or take their children with them through the field, due to risks of armed attack at home or in the field. Unlike TBAs and VHV who work within their own villages and can access their children quickly when an armed attack occurs. At the same time, the BPHWT have recruited 81 men as TBAs, which traditionally was a female occupation.

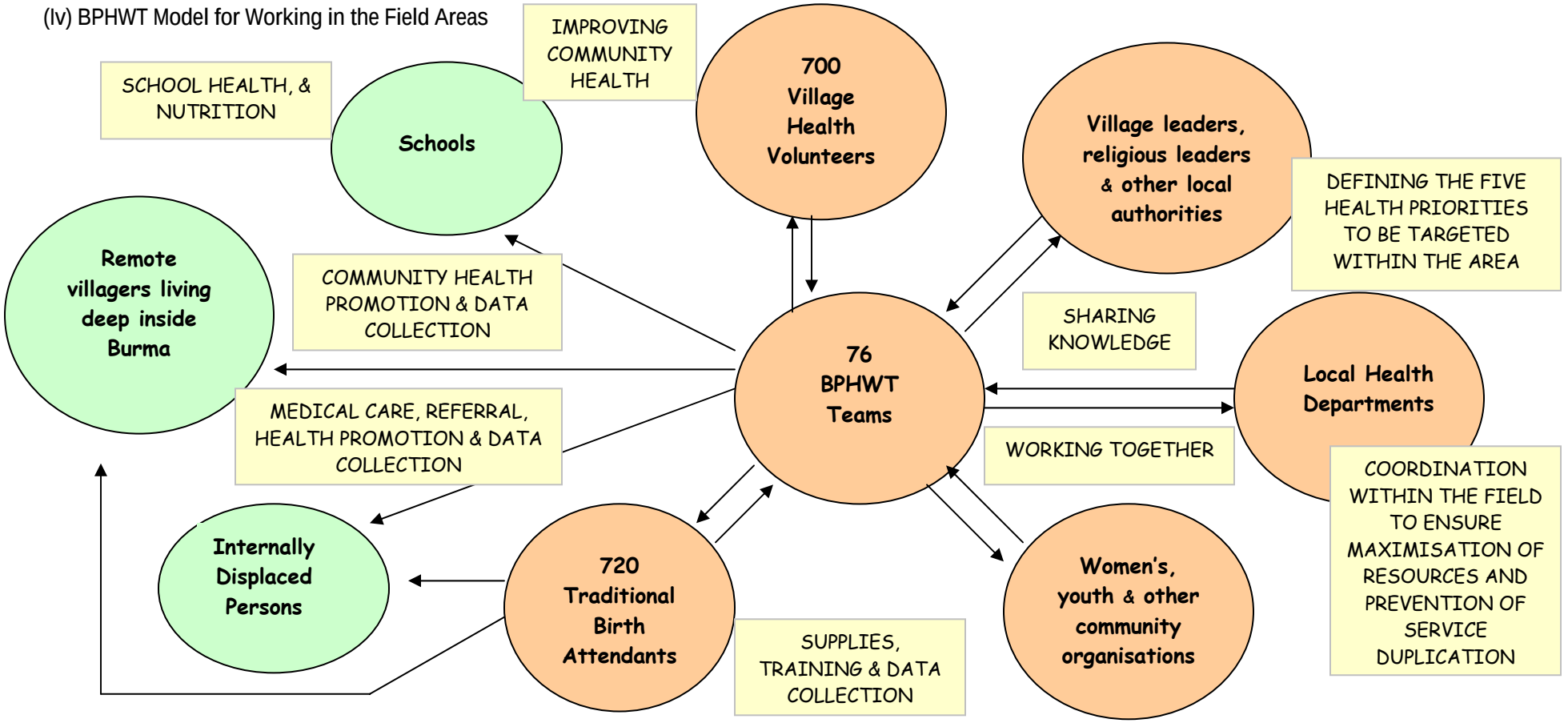
Table 1: Gender Analysis of the People Working within the BPHWT

CATEGORY	TOTAL NO OF PEOPLE	TOTAL NO FEMALES	FEMALE ACTUAL %	FEMALE TARGET %
Leading Group	13	3	23	30
Executive Board	8	2	25	40
Field Management	49	15	31	25
Field Health Workers	244	82	34	30
Traditional Birth Attendants	720	639	89	Target not set
Village Health Volunteers	700	291	42	50
Total Organisation	1,723	1,030	60	Target not set

Explanations to Table 1

1. **Leading Group:** includes 3 members of Field Management, so only 10 included in the count for Total Organisation.
2. **Executive Board:** all are members of Leading Group, so none are included in the count for Total Organisation.
3. **Field Management:** 3 members (In-charge of MCP, CHEPP and MCHP) in each field, except only 2 in 2 of the fields.
4. **Field Health Workers:** does not include Field Management.

(Iv) BPHWT Model for Working in the Field Areas



The BPHWT community development approach to delivering primary health care to people of various ethnic who are internally displaced or living in remote interior areas of Burma, demonstrates a strong commitment to the BPHWT's vision, mission and goal. The BPHWT can demonstrate their effectiveness in reducing morbidity and mortality from common diseases and in doing so they are working towards developing a healthy society in Burma. The BPHWT are empowering these communities through assisting local people to develop the skills and abilities necessary to manage and address their own health problems.

BPHWT is currently working in Shan, Karenni, Karen, Mon and Chin States; and Tennaserim Division; with a pilot project in Arakan State. Within some of these areas the BPHWT facilitates consultation and cooperation between village leaders and other local authorities; religious leaders; women's, youth and other community organisations; schools; and local health organisations to identify the five health priorities to be targeted in their area. The BPHWT seeks international funding to purchase the health care supplies to meet these five health priorities and transports these supplies into Burma. BPHWT Health Workers hold Village Health Workshops to share their public health knowledge with community members to combat communicable diseases and improve the health of the community. BPHWT also trains Village Health Volunteers to provide them with the knowledge and skills to assist the BPHWT in minimising communicable diseases through the building of safe water and sanitation systems to minimise water borne and vector illnesses. Traditional Birth Attendants also attend regular training provided by the BPHWT and are provided with the equipment to deliver babies safely and optimise the health of mothers and their new born babies.

BPHWT does not provide medical training for Field Workers, but builds on existing training systems in local communities, by providing financial support to local health authorities to assist them to provide the initial six-month Community Health Worker (CHW) training. Local health authorities and Mae Tao Clinic on the Thai-Burma border provide graduates of the CHW training with one-year supervised placements to further develop their medical skills. At the completion of the placements, Health Workers who meet the BPHWT selection criteria are nominated by their community to work with the BPHWT as Field Health Workers, when positions are available.

The collaborative BPHWT model builds on existing systems, to improve skills and knowledge within communities to enhance their ability to manage and address their own health problems. At the same time, the model is building a sustainable primary health care system, promoting different ethnic groups to work collaboratively, in preparation for the transition to democracy.

(v) Towards an Accessible Community Based Primary Health Care Service System

Since 1998, the Back Pack Health Worker Team has been working towards developing an accessible, community based, primary health care service system within their operational fields, based on the health access targets in Table 2, which includes the manpower provided by VHVs to construct 1 latrine for every 5 people.

Table 2: Health Access Targets for a Community Based Primary Health Care System

TARGET POPULATION	HEALTH SERVICE TYPE	HEALTH WORKER TYPES	RATIO (workers/pop)	TARGET NUMBER
2,000	1 x BPHWT Team (Community Based Primary Health Care Unit)	Field Management and Field Health Workers	1/400	5
		Traditional Birth Attendant (TBA)	1/200	10
		Village Health Volunteer (VHV)	1/200	10
		TOTAL HEALTH WORKERS PER BPHWT TEAM		**25**

In 2007, the BPHWT provided health care to an estimated target population of 160,000 people. As can be seen from Table 3, overall the BPHWT has achieved 86 percent of the target to provide an accessible community based primary health care system. However, the achievement is not consistent across all health worker types. The BPHWT uses the targets to plan for training or supporting the training of additional workers in the field.

Table 3: Analysis of the Current Accessibility of the BPHWT

HEALTH WORKER TYPES	TARGET NO HEALTH WORKERS FOR 160,000 PEOPLE	ACTUAL NO HEALTH WORKERS	ACCESS ACHIEVED TO DATE AS %
Field Management and Field Health Workers	400	293	73
Traditional Birth Attendant (TBA)	800	720	90
Village Health Volunteer (VHV)	800	700	87.5
TOTAL HEALTH WORKERS	**2,000**	**1,713**	**86**

(vi) Procurement and Transportation of Supplies into the Field Areas

In 2006, the BPHWT reviewed their procurement processes and requested quotes from three Thai companies for the supply of medicines and medical equipment. The BPHWT entered into contracts with two companies to purchase Thai government approved medical supplies and deliver to agreed sites, at a fixed price within a fixed time frame. In accordance with many donors, the BPHWT purchases all their supplies outside Burma and then transports them into Burma. This is an expensive logistical exercise undertaken by the BPHWT on a six monthly basis. In 2007, a private European donor funded the purchase of materials and the construction of a floating bamboo warehouse, which is now located in northern Karen area. The warehouse provides safe storage for supplies until they are able to be transported into the four northern Karen area fields.

Poor transport infrastructure within Burma ensures many supplies are carried by individuals into the field areas; over mountains and rivers. A high level of hostile military activity can delay the delivery of health supplies. People may need to wait quietly in the jungle for a few days until the SPDC and their allied soldiers leave the area.

The quantity of supplies is checked and authorised three times during the delivery process. Initially against the company invoice and BPHWT order at the delivery location; secondly when received by the field; and finally when received by the teams.

Six-months of medical supplies for the northern Karen area are transported from Thailand to Burma, via road and rivers. They are stored in a floating bamboo warehouse, until field staff arrive, to collect them - 2007

A long-tail boat being navigated through the rapids - 2007

Swimming with supplies across the river - 2007

Supplies arrive in the field and are checked - 2007

(vii) Obstacles and Threats to Delivering Health Care in the Field Areas

Delivering health care in Burma is a dangerous occupation for the BPHWT, due to the hostility of the SPDC and their allied armies and the prevalence of landmines. BPHWT Health Workers cannot move openly through many of their field areas, as they risk being captured and imprisoned, or shot by hostile soldiers. Since its inception, seven BPHWT Health Workers have been killed whilst delivering health care. One Health Worker, imprisoned in Toungoo in 2005 and three Village Health Volunteers in 2006, remain in prison. In 2007, two Health Workers from Mergue/Tavoy were arrested and one in Thaton. Their releases have been negotiated on the payment of fines of 15,000 baht per Health Worker. Supplies have regularly been stolen by the SPDC or left behind when a surprise attack takes place. To date in 2007, three backpacks of medicine and TBA kits have been stolen by the SPDC in Kawkareik. BPHWT data quality is affected by the need for many Teams and TBAs to keep their data forms hidden from SPDC authorities, as being caught with BPHWT documentation can place their lives at risk. This can lead to data sheets being lost or destroyed. Hostile military activity can also prevent data being returned to the office in a timely manner.

Providing medical care - Pa'an 2007

VI. BPHWT PROGRAMS

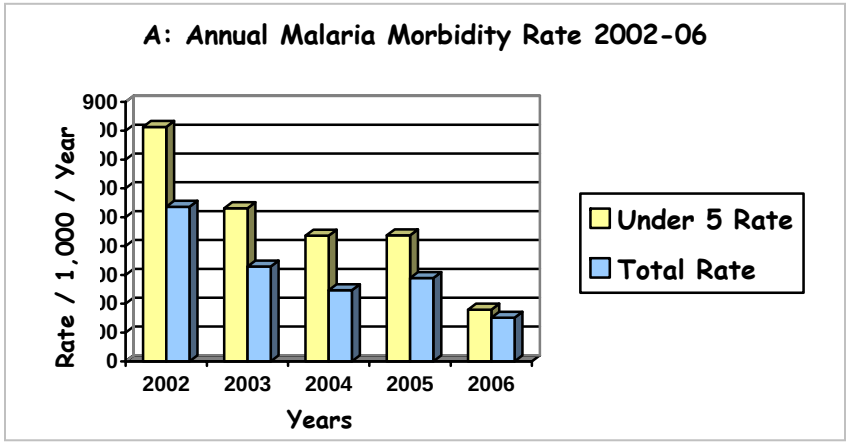
The BPHWT delivers three programs: medical care, community health education promotion, and maternal and child health. Integrated within these three programs are capacity building, health information and documentation and, monitoring and evaluation.

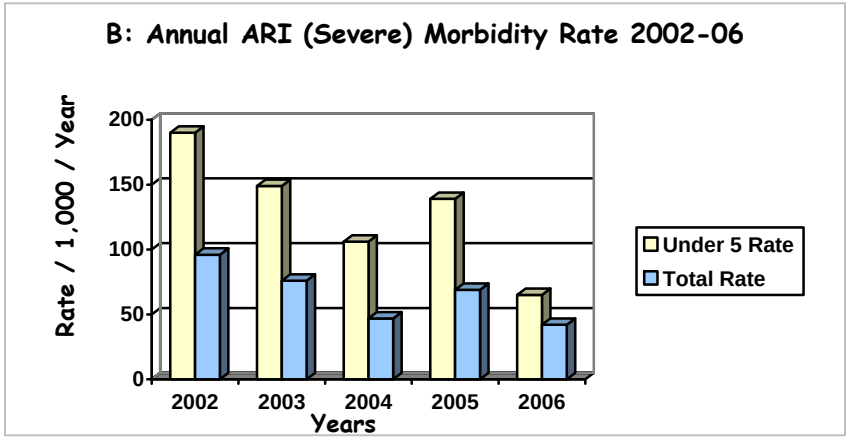
(i) Medical Care Program (MCP)

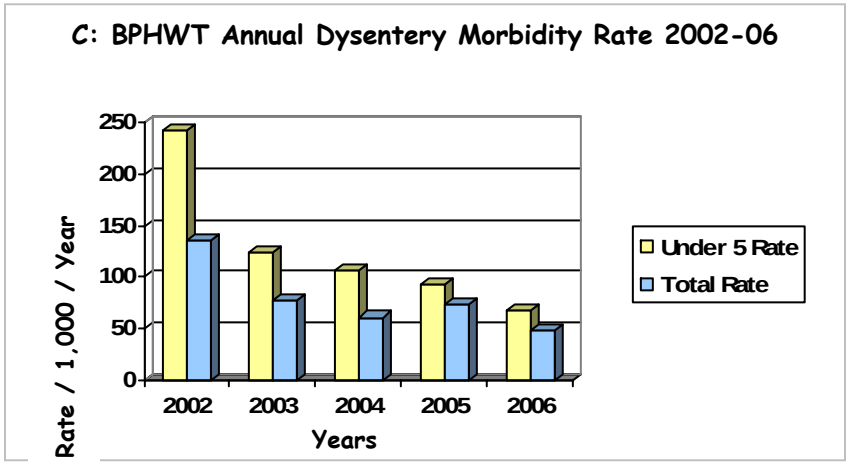
Over the last 5 years the most prevalent diseases treated by the BPHWT have been malaria, acute respiratory infections (ARI), worm infestation, anaemia and diarrhoea. In 2006 the BPHWT treated 71,789 cases, and by mid year 2007, they had treated 39,456 cases. It should be noted that some data from 2006, were stolen by the SPDC and not all data have been returned in time for inclusion in the 2007 mid-year report. All data from the field areas are carried back to the BPHWT office by Health Workers when they attend the six monthly meetings. Some times BPHWT teams are not able to attend these meetings due to the high level of military activity within their areas. Teams follow treatment protocols established on the Thai-Burma Border and printed in the BPHWT Treatment Handbook provided to all Field Workers. BPHWT plans to up-date, reprint and distribute a new handbook to its Field Workers in 2008.

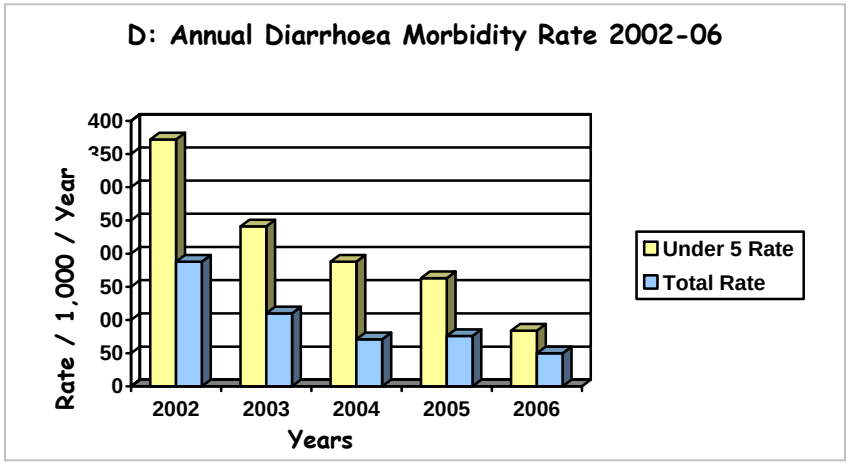
Comparisons of the overall morbidity rates from the years 2002 to 2006, of commonly treated diseases are found in the graphs below. A full analysis of all the data is included in the 2006 BPHWT Annual Report. However, the overall positive impact on the health of the target population is clearly demonstrated in the graphs below. The Annual Malaria Morbidity Rate has decreased by 70 percent, ARI (Severe) by 56 percent, Dysentery by 63 percent and Diarrhoea by 73 percent. As Malaria continues to be the greatest cause of mortality within the population being treated, the BPHWT uses Paracheck for the rapid diagnosis of malaria that is not clinically obvious or when no laboratory blood smear is able to be done.

Graphs 1: Overall Disease Specific Annual Morbidity Rates from 2002 to 2006 in BPHWT Fields





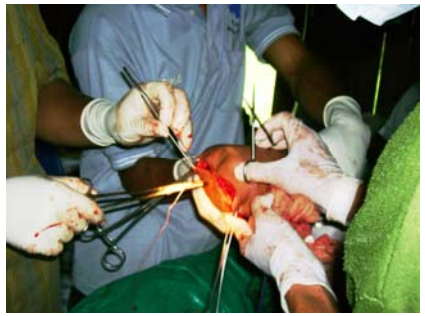




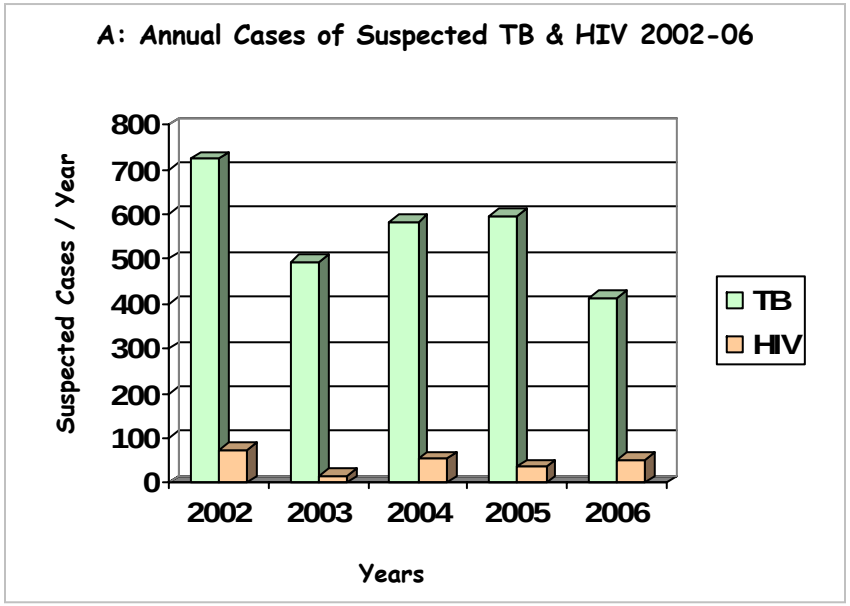
Treating a child with malaria - 2007

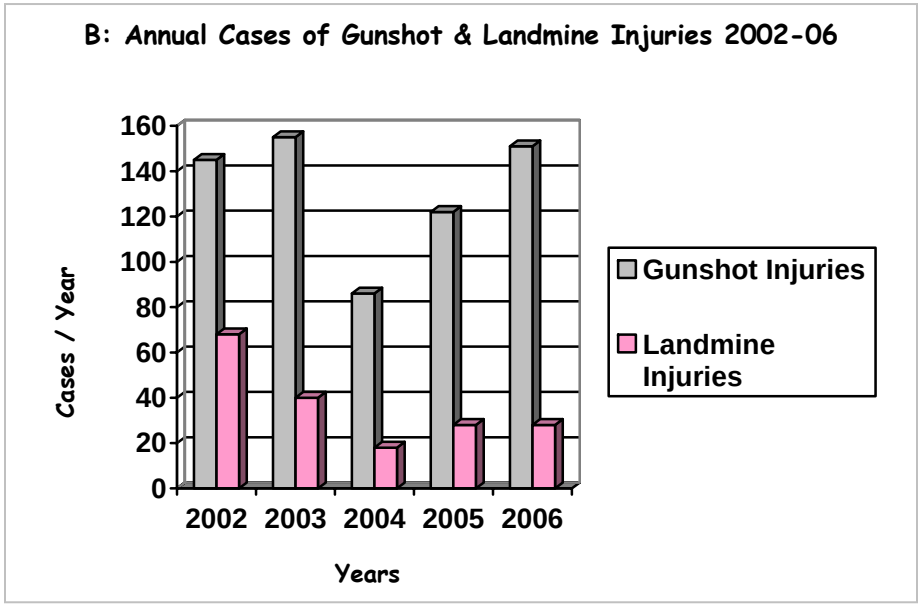
Extracting a tooth - 2007

Making a stump after an amputation on a person with a land mine injury - Papun 2007



Graphs 2: Annual Cases of Suspected TB and HIV, and War Injuries Treated from 2002 to 2006 in BPHWT Field Areas





As can be seen by Graph A, BPHWT teams diagnose cases of suspected TB and HIV, both of which are known to be prevalent in Burma. However, confirming the suspected diagnosis and providing treatment for these diseases, is currently beyond the scope of the BPHWT. Graph B represents the gunshot and landmine injuries treated by teams over the last five years and it should be noted that the majority of war injuries occur in Karen areas. As can be seen by the graph, the number of war injuries was markedly reduced in 2004 due to the short-lived ceasefire agreement in the early months of the year, between the SPDC and the Karen National Union (KNU). The graph also shows that war injuries are steadily increasing in incidence since 2004, as the SPDC intensifies the military campaigns against the KNU. Some teams experience difficulty referring patients with landmine injuries to clinics and hospitals due to: hostile military activity creating security issues; the high cost of transporting patients; and the high cost of medical treatment if the patient is required to be referred to an hospital. Lymphatic Filariasis is a severely debilitating mosquito-bone disease prevalent in Burma, which disproportionately affects the poorest people. As it is able to be controlled through an annual, single dose of an anti-parasitic drug, widely administered to the population at risk, for four to six consecutive years; the BPHWT plans to commence testing a sample of the population for Lymphatic Filariasis. If one positive sample is found the BPHWT will mass treat the entire identified population.

Transporting a patient to a referral hospital or clinic, 2006

(ii) Community Health Education and Prevention Program (CHEPP)

The CHEPP has four components:

- Community health education
- Water and sanitation
- School health
- Nutrition

Community Health Education

This component, through a variety of meetings, workshops, events, songs and documentaries provides people with knowledge about a range of health issues such as:

- Awareness and prevention of malaria, water-borne diseases, HIV/AIDS and bird flu
- Malnutrition, breastfeeding benefits and local foods high in essential nutrients
- Landmine awareness, risks and education

In 2007, over 10,000 people attended Key Health Day events that focussed on awareness and prevention of HIV/AIDS. Another Key Health Day event is planned for 2008. The BPHWT also plans to create and distribute another album of health education songs and 2 documentaries to the target population and wider international community.

To date, the BPHWT has trained 700 Village Health Volunteers but to reach a target of 1 VHV per 200 people in the target population, the BPHWT need to train a further 200 VHV to meet accessibility targets for the new target population of 180,000 people. This training is planned in 2008.

Water and Sanitation

In response to a survey undertaken in 2001 which included access to safe water and sanitation systems within the field area, the BPHWT has been installing gravity-flow, shallow-well and filtered drinking water systems and latrines, to reduce the morbidity of some common diseases. The BPHWT population targets for the installation of safe water systems are:

- 500 people for 1 gravity flow water system
- 50 people for 1 shallow-well water system
- Each school to have 1 filtered water system

Community health education session - 2007

The BPHWT also plans to build one latrine for every five people within the field. As no census has been taken to establish the level of safe water systems and latrines prior to the BPHWT commencing installation in the field, it is difficult to assess the level of achievement of these targets. However, to date the BPHWT has provided safe water systems for 15,400 members of the target population. In 2008, the BPHWT plans to install a further 20 gravity-flow and 20 shallow-well water systems, which will increase the number of people who have been provided with access to safe-water systems to 26,400. To date the Team have installed 2,400 community latrines and they plan to install another 2,000 in 2008. A target population of 180,000 people require 36,000 latrines to meet a ratio of 1 latrine for every 5 people. The BPHWT will include a census of water systems and latrines in the next annual survey.

BPHWT currently works with 441 schools and they have provided 24 of these with safe drinking water. In 2008, the BPHWT plans to provide an additional 270 schools with one filtered drinking water system. The Team has also provided these schools which have a total of 22,800 students, with 754 latrines and plans to install a further 270 school latrines in 2008. Table 4 provides information about the type and number of water systems and latrines installed by the BPHWT to date.

Table 4: Water and Sanitation Systems Installed in the Target Area 2002 - 2006

TYPE OF WATER OR SANITATION SYSTEM	2002	2003	2004	2005	2006	TOTAL
Community gravity-flow water system	-	-	-	8	20	28
Community shallow-well water system	-	-	-	2	20	28
School filtered drinking water system	24	-	-	-	-	24
Community latrines	-	-	-	400	2,000	2,400
School latrines	24	-	-	350	380	754

Water and sanitation project - Win Yee 2007

Constructing shallow-well water systems before installation - 2006

School Health

The school health component was initially implemented in 2001. Children receive hygiene education, training and basic supplies. As BPHWT programs are integrated, access to safe drinking water and latrines; nutritional supplements and de-worming medication; and medical screening and treatment is also provided to schools and their pupils. The program initially commenced with 500 pupils and has grown over the following years as demonstrated in Table 5.


School health - 2007

Table 5: School Health Activities

DESCRIPTION	2002	2003	2004	2005	2006
No of schools	32	N/A	138	306	441
No of students	2,192	N/A	9,409	17,169	22,880
No of teachers	N/A	N/A	381	805	1,115

Nutrition

The BPHWT distribute Vitamin A and de-worming medication to children and, prenatal and postpartum women under the Nutrition component of CHEPP and in the Maternal and Child Health Program, to assist in preventing malnutrition. In 2006, 24,373 women and children received de-worming medication and 26,252 women and children received Vitamin A under the nutrition program.


TBA Training - 2007

(iii) Maternal and Child Health Program (MCHP)

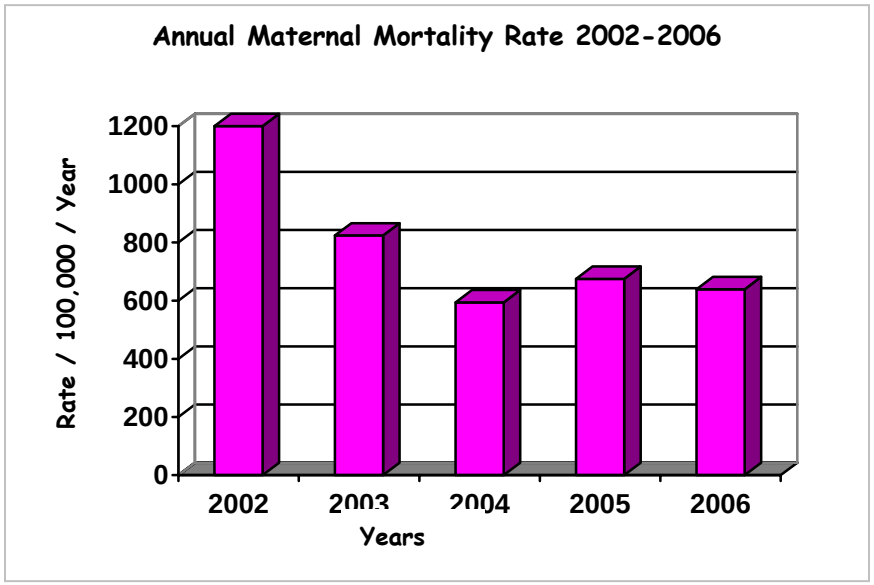
There are 17 MCH Supervisors (previously known as TBA Trainers) who deliver training to new TBAs and also provide ongoing training through Follow-up Field Workshops with existing TBAs. The MCH Supervisors attend six-monthly Reproductive Health Workshop in Mae Sot to improve their knowledge and report on activities. Less than 50 percent of maternal data is returned to the BPHWT, which is why planned TBA and Maternity Kits are significantly greater than annual recorded births. There are high levels of illiteracy amongst TBAs and this makes completing data forms difficult. Though data returns are not high, the growth in the MCHP can be seen in Table 6.

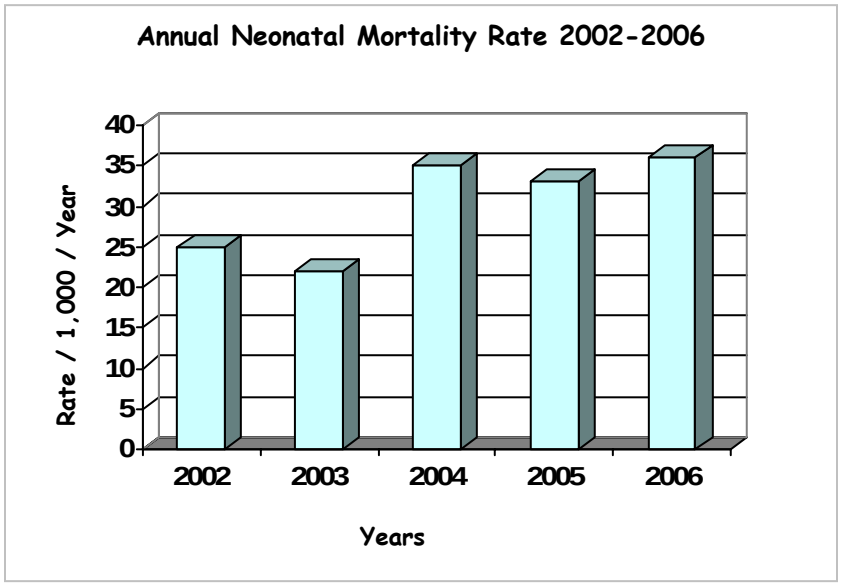
Table 6: MCHP Delivery Activity 2004 - 2006

DESCRIPTION	2004	2005	2006
Total no of Deliveries	1,432	2,297	2,693
Total no of Live births	1,347	2,222	2,594
Total no of Still births / Abortions	84	81	103
Total no of Neonatal deaths	47	73	94
Total no of Maternal deaths	8	15	15

As demonstrated in Graph 3 below, the Annual Maternal and Neonatal Mortality Rates are unacceptably high. They are twice as high as official Burmese rates and similar to those reported in Angola. Though an improvement can be seen in the Annual Maternal Mortality Rate, the same can be reported for the Annual Neonatal Rate which is increasing over time. This is an issue which needs to be addressed effectively by the MCH Program in 2008.

Graphs 3: Annual Maternal and Neonatal Mortality Rates from 2002 to 2006 in BPHWT Fields





The MCH Program also provides family planning advice and contraceptive supplies to people within the field areas, to assist in promoting the improved health of women and children. Table 7 provides an annual summary of family planning activities from 2004 to 2006. It is not possible to make any inferences from this data, but it is essential to collect for planning purposes. Previously BPHWT received donated family planning however, in 2008, the BPHWT will purchase all supplies.

Table 7: Family Planning Activities 2004 - 2006

DESCRIPTION	2004	2005	2006
No of people seeking family planning	1,262	1,262	1,670
No of depot injections administered - single unit, effective for 3 months	1,210	1,214	1,523
No of contraceptive pills supplied - single unit, effective for 1 month	2,103	2,227	2,462
No of individual condoms supplied	2,016	6,028	4,478

(iv) Integrated Capacity Building

In addition to the training already discussed integrated through the three main programs, the BPHWT plans further capacity building activities for members of the Leading Group and the Coordination Staff to ensure that programs are managed effectively and the organisation strives for continuous quality improvement. In 2008, the BPHWT plans to provide the following training and resources to improve health delivery, health information and documentation, advocacy and financial management skills.

- Provide financial support for 3 Community Health Worker training sessions in the field
- Health information training
- Computer training
- Purchase of 90 digital (still) cameras, to record health activities and human rights abuses in the field areas
- Video and photo documentation training
- Purchase and develop films for non-digital cameras used for documentation in the fields
- Finance/accounting training
- Purchase accounting software to improve the production of financial records and reports
- Attendance at local and international conferences for members of the Leading Group to promote a greater world understanding of the health and human rights situation in Burma, the activities of the BPHWT and to learn from the activities of other organisations and individuals
- Produce two educational documentaries for distribution within fields and the international community
- Publish a calendar with health messages
- Purchase health education materials for use in the field
- Improve communication within the field and from the field to the office, through the purchase of additional effective communication equipment

Some examples of international advocacy and capacity building undertaken by Leading Group members in 2007 include: participation in the annual Norwegian Church Aid campaign to raise funds through presentation of the health and human rights issues in Burma; presentation of health and human rights issues in Burma, at 34 Global Health conference in New York; attendance at a two week training course in Bangkok on public health disaster preparedness.

With some technical assistance from international volunteers, BPHWT revised their documentary about the health and human rights situation in eastern Burma, and the documentary, now called *Chronic Emergency,* is to be shown at the Sydney site of the Inaugural Australian Health and Human Rights Arts and Film Festival, in November 2007. A full description of capacity building activities will be included in the 2007 Annual Report.

In 2008, the BPHWT would also like to construct another meeting and training room. BPHWT assists in facilitating cooperation among organisations working to deliver services of all types to people living inside Burma, refugees on the Thai-Burma border and Burmese migrant workers. BPHWT views this cooperation across organisations and across ethnic nationalities as important preparation for the future when democracy is returned to Burma.

VII. COORDINATION AND COOPREATION

The Back Pack Health Worker Team coordinates with other health organizations, health professionals and health institutions that have the same community health vision. To review the effectiveness of the program, the BPHWT organized coordination meetings every six months, in conjunction with the regular BPHWT general meetings, field workshops, field operational meetings and village workshops. The executive committee of BPHWT coordinates with other health organizations which work in areas related to the programs or issues, such as: Mae Tao Clinic, Burma Medical Association (BMA), local ethnic health departments, National Health and Education Committee (NHEC). The technical assistance of BPHWT supported by Global Health Access Program (GHAP) , in terms of designing of public health, data instrument, preparation and monitoring of health indicators.

The field in-charge from fifteen field areas organized field meetings every six months, which included coordinated activities with local health organizations. The BPHWT mainly cooperates with ethnic local health departments, local community based organizations, school teachers and village leaders.

VIII. LOGICAL FRAMEWORK FOR BPHWT PROGRAMS IN 2008

Table 8 provides detail of the 13 objectives of the BPHWT programs and describes the activities, indicators of achievements, verification sources, expected outcomes and the risks involved in the delivery of the programs.

Table 8: Logical Framework for BPHWT Programs in 2008

OVERALL GOAL	**To reduce morbidity & mortality & minimise disability by enabling & empowering the community through primary health care**				
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**EXPECTED OUTCOMES**	**RISKS**
1. To increase the target population	- Liaise with local ethnic health departments & communities	- New fields & teams implemented - More Field Health Workers recruited	- Field reports - Field photos - Health Workers registered - Annual population census	Target population increased to: - 180,000 people	- Insufficient Field Health Workers recruited
2. To decrease the morbidity & mortality rates from common diseases	- Procure and transport medical supplies - Treat common diseases and minor injuries	- Supplies transported to field - No of cases treated - Rate of morbidity - Rate of mortality	- Delivery documents - Log books - Analysis of data collected - Mid year & Annual Reports - Impact Assessment Survey	- 108,000 cases being treated - reducing morbidity rates by 15% through out a year - reducing mortality rates 25% within 2 years	- Insufficient funding - Medical supplies stolen by SPDC - Data lost, stolen or incomplete
3. To strengthen patient referral systems	- Field Meetings - Village Health workshops - 6 monthly meetings	- No of participants in workshops & meetings - No of referrals	- Meeting reports - Workshop reports - Mid year & Annual Reports -Patient's referral form	- 20,000 people attend meetings & workshops -190 patients referred to clinics or hospitals	- High cost of transporting patients - High cost of medical care at referral sites
4. To respond to disease outbreaks and emergency situations	- Purchase emergency medical supplies - Improve communication within the field and from field to office	- Prompt reporting - Population affected - No of cases treated	- Delivery documents - Field photos - Exceptional reports - Mid year & Annual Reports	- Effective response and treatment for disease outbreaks or emergency situations	- Delay in field reporting outbreak or emergency - Hostile military activity delays or prevents mobilisation
5. To improve Health Workers skills and knowledge	- Field workshops - 6 month workshops - reviewing logbooks	- No of Health Workers participated - Improved diagnosis & treatment	- Field reports - Workshop reports - Log book review & analysis - Mid year & Annual Reports	- 270 attend Field Workshops - 90 attend 6 month workshops	- High risk travel due to security issues

OVERALL GOAL	To reduce morbidity & mortality & minimise disability by enabling & empowering the community through primary health care				
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**EXPECTED OUTCOMES**	**RISKS**
6. To improve networking among community health organisations	- Field meetings - Village Health Workshops	- No & category of people who participate in workshops and meetings	- Field Meeting reports - VH Workshop reports - Field reports - Field photos - Mid year & Annual Reports	- 20,000 people participate in 150 Village Health Workshops - Breakdown of participants by category (women, youth, TBA, VHV, shopkeepers. leaders, teachers etc)	- Time limitations of community members
7. To reduce incidence of malnutrition & worm infestation	- Distribute Vitamin A & de-worming to children, prenatal & post-partum women - Distribute iron to children	- No of people who receive Vitamin A, de-worming & iron	- Data forms - Data analysis - Field photos - Mid year & Annual Reports	- 39,000 people received Vitamin A - 22,500 people received de-worming medicine - 27,500 children received iron	- Delay in Vitamin A arriving from international donor
8. To educate students & the community about health	- Student personal hygiene sessions - Key Health Day events - Health Song Album	- No of personal hygiene sessions held & no of students participating - No of Key Health Day events held & no of participants - No of Health Song Albums distributed	- Field reports - Field photos - Mid year & Annual Reports	- 180 personal hygiene sessions attended by 27,000 students - 90 Key Health Day events attended by 11,000 people - 500 copies Health Song Albums distributed across field	- Time limitations of community members
9. To equip the people with the skills and abilities to manage their own health	- VHV Training Sessions - VHV Workshops - Village Health Workshops	- No of VHV Training Sessions & No of new VHVs trained - No of VHV Workshops & No of VHVs attending	- Training and Workshop reports - Photos - Mid year & Annual Reports	- 200 new VHV trained in 20 VHV Training Sessions - 140 VHV Workshops attended by 1400 VHVs	- SPDC have arrested VHVs, which may limit community members from becoming involved
10. To improve water and sanitation systems in the community to reduce water-borne diseases	- Install pure drinking water systems in schools - Build gravity flow & shallow well water systems - Build school & community latrines	- No & type of water systems installed - No & type of latrines built - Reduced morbidity from water-borne diseases	- Field reports - Photos - Mid year & Annual Reports	- 90 school pure drinking water systems - 20 gravity flow water systems - 20 shallow well water systems - 270 school latrines - 2000 community latrines	- Insufficient funding - Hostile military activity prevents transportation and installation

OVERALL GOAL	To reduce morbidity & mortality & minimise disability by enabling & empowering the community through primary health care				
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**EXPECTED OUTCOMES**	**RISKS**
11. To reduce maternal & neonatal mortality rates	- New TBAs trained - TBA Kits provided to all TBAs - Maternity Kits provided to all TBAs	- No of new TBAs - No of TBA kits provided - No of Maternity Kits provided - No of live-birth, maternal and neonatal death	- Workshop reports - TBA' data form - Mid year & Annual Reports	- 200 new TBAs with training at 20 TBA Training sessions - 1,980 TBA Kits - 9,900 Maternity Kits	- Under recording of maternal deaths - Security issues can affect data level returned
12. To improve knowledge & skills of TBAs & MCH Supervisors	- TBA Follow-up Workshops held - Reproductive Health Workshops held	- No of TBA Follow-up Workshops held & no of TBAs attending - No of Reproductive Health Workshops held & No of MCH Supervisors attending	- Workshop reports - Field reports - Field photos - Mid year & Annual Report	- 150 Follow-up TBA Workshops for 990 TBAs - 2 Reproductive Health Workshops for 19 MCH Supervisors	- Security issues affect travel
13. To encourage positive community attitudes towards and utilization of family planning	- Village Health Workshops - Reproductive Health Workshops	- No or participants at workshops - No & type of contraceptive supplies provided	- Data sheets & analysis of data - MCH Supervisor reports - Mid year & Annual Reports	- 1,700 people participate in family planning	- Traditional cultural barriers

Program Activity Time Lines

Though many BPHWT activities can be disrupted by the military activity of the SPDC and their allied armies, Table 9 provides the planned implantation timelines for activities.

Table 9: Program Activity Time Lines

ACTIVITIES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1. Provide medical care	√	√	√	√	√	√	√	√	√	√	√	√
2. Deliver healthcare supplies			√							√		
3. Distribute Ferrous sulphate			√	√	√				√	√	√	
4. Distribute Vitamin A			√	√					√	√		
5. Distribute De-worming medication			√	√					√	√		
6. Filariasis sampling & treatment			√	√					√	√		
7. Field Meeting	√						√					
8. Field Workshop		√						√				
9. Village Health Workshop			√	√					√	√		
10. VHV Training				√								
11. VHV Workshop			√					√				
12. School health & nutrition						√					√	
13. Water & sanitation installation			√	√					√	√		
14. Key Health Day												√
15. Create documentary			√	√	√	√			√	√	√	√
16. Create health song album			√	√	√	√	√					
17, TBA Training				√						√		
18. TBA Workshop				√						√		
19. Program Analysis Meeting	√						√					
20. Program Meeting		√						√				
21. Program Workshop		√						√				
22. Log book reviews		√						√				
23. Data entry		√	√					√	√			
24. Coordination Staff Meeting	√	√	√	√	√	√	√	√	√	√	√	√
25. Executive Board Meeting	√	√	√	√	√	√	√	√	√	√	√	√
26. Leading Group Meeting			√						√			
27. Six Monthly Meeting		√						√				
28. Annual General Meeting		√										
29 Health Workers Assessment			√	√								
30. Monitoring Trip				√								
31. Impact Assessment Survey												√
32. Reporting				√						√		

IX. MANAGEMENT, MONITORING & EVALUATION

(i) Organisational Management and Development

There are a range of documents that guide the management of the BPHWT and Table 10 gives a summary of the internal reporting framework.

Table 10: Internal Reporting Framework

HUMAN RESOURCES	GUIDING DOCUMENTS	AVENUE	FREQUENCY	EVIDENCE
Field Workers report to Fields-in-Charges	- Duty statements - Treatment handbook	Field Meeting	Monthly	- Team Activity Reports
Fields-in-Charge report to Program Coordinators	- Duty statements - Policies & procedures	Program Meeting	6 Monthly	- Field Activity Reports
Coordination staff report to Director	- Duty statements - Policies & procedures	Coordination Staff Meeting	Monthly	- Coordination Staff Meeting Reports
Program Coordinators report to Director	- Duty statements - Policies & procedures	Executive Board Meeting	Monthly	- Program Reports - Executive Board Meeting Reports
Director reports to Leading Group	- Duty statement - Policies & procedures - Constitution - Funding contracts	Leading Group Meeting	Twice Yearly	- Combined Program Reports - Leading Group Meeting Reports
Chairperson & Director report to BPHWT members	- Constitution - Funding contracts	Annual General Meeting	Annually	- Annual General Meeting Report - Annual Report & Audited Financial Statements

BPHWT receives technical assistance from external consultants and organisations to develop and improve programs. Some examples of the technical assistance BPHWT have received in 2007 include: reviewing field log books; reviewing and rationalising drug treatment; improving data management and analysis; improving reporting documentation; and the development of presentations in the international arena.

(ii) Program Monitoring and Evaluation

The BPHWT undertakes a range of monitoring and evaluation activities, some of which are conducted by external consultants or organisations. Table 11 summarises the current Monitoring and Evaluation framework.

Table 11: Monitoring and Evaluation Framework

TOPIC	METHOD	PARTICPANTS	FREQUENCY	EVIDENCE & REPORTING
Quality of Field Health Worker's medical skills	Logbook reviews	- External Physician - Fields-in-Charge - Program Coordinator	6 monthly	Logbook review and analysis included in the Annual Report
Program implementation	Comparison of planned and actual activities	- Leading Group - Fields-in-Charge	Annually	Comparison and reasons for variance included in the Annual Report
Effectiveness of VHV & TBA Training	Pre and post testing of participants	- Executive Board - Program Coordinators	Annually	Results of training evaluation included in the Annual Report
Effectiveness of Programs in improving health outcomes	Calculating morbidity rates of common diseases	- Executive Director - HIS staff - Program Coordinators	Annually	Morbidity rates over time included in the Annual Report
	Impact Assessment	- Survey team	Two yearly	Impact assessment included in the corresponding Annual Report
Financial management	Comparison of budget & actual income & expenditure	- Leading Group - Fields-in-Charge	6 monthly	Comparison and explanation of variances included in the 6 monthly and Annual Reports
	Financial Audit	- External Auditing Firm - Director - Finance Manager - Accountant	Annually	Audited Financial Report included in the Annual Report
Satisfaction with Organisational Management	Election of Leading Group	- All BPHWT members	Three yearly	Outcome of elections included in corresponding Annual Report

XI. BUDGETING (January to December S2008)

BPHWT January to December 2008 Budget					
Items	**Jan-Jun 08**	**Jul-Dec 08**	**Total**	**% total budget**	**% by program**
I. Medical Care Program (MCP)					
A) MCP program operation cost					
1. Program coordinator operation cost (5,000 B x 6 mths x 1 person)	30,000	30,000	60,000	0.2%	1%
2. Program staff operation cost (4,000 B x 6 mths x 1 person)	24,000	24,000	48,000	0.2%	0%
MCP program operation cost sub total	**54,000**	**54,000**	**108,000**	**0.4%**	1%
B) MCP Activities and supplies					0%
1. Medicines (40,000, B x 90 BP)	3,600,000	3,600,000	7,200,000	23.6%	63%
2. Malaria rapid test 40 B x 200 x 90 BP	720,000	720,000	1,440,000	4.7%	13%
3. Filariasis test 100 B x 500	50,000	0	50,000	0.2%	0%
4. DEC and Albendazole medicines	50,000	50,000	100,000	0.3%	1%
3.Medicine transportation (3,000 B x 90 BP)	270,000	270,000	540,000	1.8%	5%
4. BP worker's operation cost (1,000 B x 6 mths x 90 persons)	540,000	540,000	1,080,000	3.5%	9%
5. Field-coordinator operation cost (1200 B x 6 mths x 19 person)	136,800	136,800	273,600	0.9%	2%
6. Emergency medical supply	250,000	250,000	500,000	1.6%	4%
7. Treatment Hand Book (200 Bx500 Books)	100,000		100,000	0.3%	1%
MCP Activities and supplies sub total	***5,716,800***	***5,566,800***	***11,283,600***	**36.9%**	**99%**
MCP Sub Total	***5,770,800***	***5,620,800***	***11,391,600***	**37.3%**	***100%***
II. Community Health Education and Prevention Program (CHEPP)					
A) Program operation cost					
1. Program coordinator operation cost (5,000 B x 6 mthsx 1 person)	30,000	30,000	60,000	0.2%	1.0%
2. Program staff operation cost (4,000 B x 6 mths x 1 person)	24,000	24,000	48,000	0.2%	0.8%
3.Worker operation cost (1000 B x 6 mths x 90 person)	540,000	540,000	1,080,000	3.5%	18.5%
4. Field coordinator operation cost (1200 B x 6 moths x 19 fields)	136,800	136,800	273,600	0.9%	4.7%
Program operation cost sub total	***730,800***	***730,800***	***1,461,600***	**4.8%**	**25.0%**
B) Village Health Volunteer workshop (2000 B x 70 session)	140,000	140,000	280,000	0.9%	4.8%
VHV workshop sub total	***140,000***	***140,000***	**280,000**	**0.9%**	**4.8%**
C) School Health Promotion					
1. Pure drinking water system (2,000 B x 90 sessions)	0	180,000	180,000	0.6%	3.1%
2. Personal hygiene (25 B x 150 students) x 90 BPs	337,500	337,500	675,000	2.2%	11.6%
3. Latrine (500B x 3 x 90 sessions)	135,000	0	135,000	0.4%	2.3%
4. Key health day event (2,000 B x 90 sessions)	0	180,000	180,000	0.6%	3.1%
5. Ferrous sulphate distribution (10 B x 150 students x 90 BPs)	135,000	135,000	270,000	0.9%	4.6%
6. Create Health Song	50,000		50,000	0.2%	0.9%
School Health Promotion sub total	**657,500**	**832,500**	**1,490,000**	**4.9%**	**25.5%**

D) Village Health Workshop (3000 B x 90 session)	**270,000**	**270,000**	**540,000**	**1.8%**	**9.2%**
E) Water & Sanitation					
1. Gravity flow water system (35,000 B x (10 +10) sessions	350,000	350,000	700,000	2.3%	12.0%
2. Shallow well water system (5,000 B x (10 +10) sessions	50,000	50,000	100,000	0.3%	1.7%
3. Community Latrine (500B x 1000 +1000 latrines)	500,000	500,000	1,000,000	3.3%	17.1%
Water & Sanitation sub total	***900,000***	***900,000***	***1,800,000***	**5.9%**	**30.8%**
F) Nutrition Promotion					
1. Vitamin A distribution(1000B x90BP)	90,000	90,000	*180,000*	0.6%	3.1%
2. Deworming for mebendazole (500 B x 90 BP)	45,000	45,000	90,000	0.3%	1.5%
Nutrition promotion sub total	**135,000**	**135,000**	**270,000**	**0.9%**	**4.6%**
CHEPP sub total	***2,833,300***	***3,008,300***	***5,841,600***	**19.1%**	***100.0%***
III. Maternal and Child Health Program (MCHP)					
A) Program operation cost					
1. Program coordinator operation cost (5,000 Bx 6 mths x1 person)	30,000	30,000	60,000	0.2%	1%
2. program staff operation cost (4,000 B x 6 mths x 1 person)	24,000	24,000	48,000	0.2%	1%
3. BP worker's operation cost (1,000 B x 6 mths x 90 persons)	540,000	540,000	1,080,000	3.5%	19%
4. Fied coordinator operation cost (1,200B x 6 mths x 19 person)	136,800	136,800	273,600	0.9%	5%
MCHP program operation cost sub total	***730,800***	***730,800***	***1,461,600***	**4.8%**	**26%**
B) TBA training					
1. Food (40 Bx 12 persons x 7 days x 10sessions)	33,600	0	33,600	0.1%	1%
2. TBA Kit (400B x 10 TBAs x 10 sessions)	40,000	0	40,000	0.1%	1%
3. Maternity Kit (150 B x 5 mothers x 10 TBAs x 10 sessions)	75,000	0	75,000	0.2%	1%
4. Stationery and documentation (1,000B x 10 sessions)	*10,000*	0	10,000	0.0%	0%
5. TBA and Maternity kit transportation (1,500 B x 10 sessions)	15,000	0	15,000	0.0%	0%
6. TBA trainees Transport (500B x 10 TBAs x 10 sessions)	50,000	0	50,000	0.2%	1%
7. Trainer honourium (2000 B X 10 session)	20,000	0	20,000	0.1%	0%
MCHP New TBA training sub total	***243,600***	***0***	***243,600***	**0.8%**	**4%**
C) TBA Field Workshop					
1. Food (40 B x12 persons x 3 days x 70 -80 sessions)	100,800	115,200	216,000	0.7%	4%
2. TBA Kit (400 B x 10 TBAs x 70-80 sessions)	280,000	320,000	600,000	2.0%	11%
3. Maternity Kit (150 B x 5 mothers x 10 TBAs x 70 - 80 sessions)	525,000	600,000	1,125,000	3.7%	20%
4. TBA and Maternity kit transportation (1500 B x 70 - 80 sessions)	105,000	120,000	225,000	0.7%	4%
5. Stationery and documentation (500B x 70 - 80 sessions)	35,000	40,000	75,000	0.2%	1%
6. TBA compensation (500 B x 700 - 800 TBAs)	350,000	400,000	750,000	2.5%	14%
MCHP Followup workshop sub total	***1,395,800***	***1,595,200***	***2,991,000***	**9.8%**	**54%**
D) Delivery record	***30,000***	***0***	**30,000**	**0.1%**	
E) Integreated TBA's activity					
a) TBA training					
1. Food (40 Bx 12 persons x 7 days x 10 sessions)	33,600	0	33,600	0.1%	1%

2. TBA Kit (400B x 10 TBAs x 10 sessions)	40,000	0	40,000	0.1%	1%
3. Maternity Kit (150 B x 5 mothers x 10 TBAs x 10 sessions)	75,000	0	75,000	0.2%	1%
4. Stationery and documentation (1,000B x 10 sessions)	10,000	0	10,000	0.0%	0%
5. TBA and Maternity kit transportation (1,500 B x 10 sessions)	15,000	0	15,000	0.0%	0%
6. TBA trainees Transport (500B x 10 TBAs x 10 sessions)	50,000	0	50,000	0.2%	1%
7. Trainer honourium (2000 B X 10 session)	20,000	0	20,000	0.1%	0%
MCHP New TBA training sub total	***243,600***	***0***	***243,600***	**0.8%**	**4%**
b) TBA Field Workshop					
1. Food (40 B x12 persons x 3 days x 9 -18 sessions)	12,960	25,920	38,880	0.1%	1%
2. TBA Kit (400 B x 10 TBAs x 9-18 sessions)	36,000	72,000	108,000	0.4%	2%
3. Maternity Kit (150 B x 5 mothers x 10 TBAs x 9 - 18 sessions)	67,500	135,000	202,500	0.7%	4%
4. TBA and Maternity kit transportation (1500 B x 9- 18 sessions)	1,350	27,000	28,350	0.1%	1%
5. Stationery and documentation (500B x 9- 18 sessions)	4,500	9,000	13,500	0.0%	0%
6. TBA compensation (500 B x 90 - 180 TBAs)	45,000	90,000	135,000	0.4%	2%
7. Facilitator honourium (2000 B X 9 - 18 session)	18,000	36,000	54,000	0.2%	1%
MCHP Followup workshop sub total	***185,310***	***394,920***	***580,230***	**1.9%**	**10%**
MCHP Sub Total	***2,829,110***	***2,720,920***	***5,550,030***	**18.2%**	***100%***
IV. Capacity Building Program (CBP)					
1. Upgrate Computer training (20,000 B x 1 training)	0	20,000	20,000	0.1%	1%
3. Health information training (30,000 B x 1 training)	30,000	0	30,000	0.1%	1%
4. CHW training (200,000 B x 3 training)	600,000	0	600,000	**2.0%**	27%
5. Local and International Conference and Training	250,000	250,000	500,000	1.6%	23%
6. Photo and Video documentation training	20,000	0	20,000	0.1%	1%
7. Building for Meeting and Training Hall	1,000,000	0	1,000,000	3.3%	45%
8.Accounting Training and Accounting Soft ware update training	30,000		30,000	0.1%	1%
CBP sub total	***1,930,000***	***270,000***	***2,200,000***	**7.2%**	***100%***
V. Health Information and Documentation (HID)					
1. Still digital camera 8000 x (50 - 40)	400,000	320,000	720,000	2.4%	47%
2. Mobile Solar (4000 B x 25 x 6mths)	100,000	100,000	200,000	0.7%	13%
3. Film and development (300 B x 90 films)	27,000	27,000	54,000	0.2%	4%
4. Video tape (350 B x 30 tapes)	10,500	10,500	21,000	0.1%	1%
5. Production documentary	70,000	70,000	140,000	0.5%	9%
6. Publication (Calendar)	30,000		30,000	0.1%	2%
7. Report Form	7,500	7,500	15,000	0.0%	1%
8. Logbook	15,000	15,000	30,000	0.1%	2%
9. Communication Equipment (6000B x 50)	300,000		300,000	1.0%	20%
10. Health worker assesment	10,000		10,000	0.0%	1%
HID sub total	***970,000***	***550,000***	***1,520,000***	**5.0%**	***100%***

VI. Program Management and Evaluation					
A) Program managing cost					
1. Leading members stipend (5,000 B x 6 persons x 6 mths)	180,000	180,000	360,000	1.2%	13%
2. Director stipend (6,000 B x 1 person x 6 mths)	36,000	36,000	72,000	0.2%	3%
3. Deputy director stipend (5,000 B x 1 person x 6 mths)	30,000	30,000	60,000	0.2%	2%
4. Finance manager stipend (5,000 B x 1 person x 6 mths)	30,000	30,000	60,000	0.2%	2%
5. Accountant stipend (4,000 B x 1 person x 6 mths)	24,000	24,000	48,000	0.2%	2%
7. Coordination with local authority	35,000	35,000	70,000	0.2%	3%
Program managing cost sub total	***335,000***	***335,000***	**670,000**	**2.2%**	**25%**
B) Medical Care Program Workshop					
1. Food (70 B x 33 persons x 7 days)	16,170	16,170	32,340	0.1%	0%
2. Stationery (5,000 B x 1 session)	5,000	5,000	10,000	0.0%	0%
3. Local transportation and security (7,000 B x 1 session)	7,000	7,000	14,000	0.0%	0%
4. Distance transportation (2,000 B x 33 persons)	66,000	66,000	132,000	0.4%	1%
5. Personal effect while in Mae Sod (500 B x 33 persons)	16,500	16,500	33,000	0.1%	0%
MCP workshop sub total	***110,670***	***110,670***	**221,340**	**0.7%**	**2%**
C) CHEPP Program Workshop					
1. Food (70 B x 33 persons x 7 days)	16,170	16,170	32,340	0.1%	0.6%
2. Stationary (5,000 B x 1 session)	5,000	5,000	10,000	0.0%	0.2%
3. Local transportation and security (7,000 B x 1 session)	7,000	7,000	14,000	0.0%	0.2%
4. Distance transportation (2,000 B x 33 persons)	66,000	66,000	132,000	0.4%	2.3%
5. Personal effect while in Mae Sod (500 B x 33 persons)	16,500	16,500	33,000	0.1%	0.6%
CHEPP workshop sub total	***110,670***	***110,670***	**221,340**	**0.7%**	**3.8%**
D) Mother and Child Health Program workshop					
1. Food (70 B x 33 persons x 7 days)	16,170	16,170	32,340	0.1%	1%
2. Stationery and Documentation (5,000 B x 1 session)	5,000	5,000	10,000	0.0%	0%
3. Local transportation and security (7,000 B x 1 session)	7,000	7,000	14,000	0.0%	0%
4. Distance transportation (2,000 B x 33 persons)	66,000	66,000	132,000	0.4%	2%
5. Personal effect while in Mae Sod (500 B x 33 persons)	16,500	16,500	33,000	0.1%	1%
RH workshop sub total	***110,670***	***110,670***	**221,340**	**0.7%**	**4%**
E) General Meeting and Seminar					
1. Food (70 B x 100 persons x 21 days)	147,000	147,000	294,000	1.0%	11%
2. Stationery (10,000 B)	10,000	10,000	20,000	0.1%	1%
3. Local Transport (1,000 B x 21 days)	21,000	21,000	42,000	0.1%	2%
4. Security (20,000 B)	20,000	20,000	40,000	0.1%	1%
5. Distant Transport (2,000 B x 6 persons)	12,000	12,000	24,000	0.1%	1%
6. Translator fees (2,000 B x 4 persons)	8,000	8,000	16,000	0.1%	1%
7. Personal need (500 B x 15 persons)	7,500	7,500	15,000	0.0%	1%
8. Decoration (5,000 B)	5,000	5,000	10,000	0.0%	0%
General Meeting and Seminar sub total	***230,500***	***230,500***	**461,000**	**1.5%**	**17%**

F) Field Meeting and Workshop					
a.Field Meeting					
1. stationery and documentation (1,000 B x 19 fields)	19,000	19,000	38,000	0.1%	1%
2. Food and supplies (6,000 B x 19 fields)	114,000	114,000	228,000	0.7%	9%
3. Field Coordination (1500 x 19 fields)	28,500	28,500	57,000	0.2%	2%
3.Transportation (3,000 B x 19 fields)	57,000	57,000	114,000	0.4%	4%
Field Meeting sub total	*218,500*	*218,500*	437,000	1.4%	16%
b.Field Workshop					
1. stationery and documentation (1,000 B x 19 fields)	19000	19,000	38,000	0.1%	1%
2. Food and supplies (5,000B x 19 fields)	95,000	95,000	190,000	0.6%	7%
3.Transportation (1,000 B x 19 fields)	19,000	19,000	38,000	0.1%	1%
Field workshop/Seminar sub total	133,000	133,000	266,000	0.9%	10%
Field Meeting and Workshop Sub- Total	**351,500**	**351,500**	**703,000**	**2.3%**	**26%**
G) Program Monitoring and Evaluation					
1. Monitoring trip (30,000 B x 1 trip)	30,000	30,000	60,000	0.2%	2%
2. Annual Impact survey (70,000 B x 1 survey)	0	70,000	70,000	0.2%	3%
Program monitoring and evaluation sub total	***30,000***	***100,000***	**130,000**	**0.4%**	**5%**
H) Management Meeting					
1. Leading group meeting (5,000 B x 1 meeting)	5,000	5,000	10,000	0.0%	0%
2. Executive Board meeting (1,000 B x 6 meeting)	6,000	6,000	12,000	0.0%	0%
3. Staffs meeting (500 B x 24 meeting)	12,000	12,000	24,000	0.1%	1%
Management Meeting sub total	***23,000***	***23,000***	**46,000**	**0.2%**	**2%**
Program Management and Evaluation sub total	***1,302,010***	***1,372,010***	***2,674,020***	**8.8%**	***100%***
VII. General Administration					
1. Office running cost (40,000 B x 6 months)	240,000	240,000	480,000	1.6%	35%
2. Office furniture	15,000	0	15,000	0.0%	1%
3.Transfer Fees	6,000	6,000	12,000	0.0%	1%
4. Office staff' stipend (4,000 B x 3 persons x 6 mths)	72,000	72,000	144,000	0.5%	10%
5. Office manager stipend (4,000 x 1person x 6 mths)	24,000	24,000	48,000	0.2%	3%
6. Social support and emergency health care	100,000	100,000	200,000	0.7%	14%
7. Registration (5000 B x 6 Persons)	30,000	0	30,000	0.1%	2%
8.Intern stipend (1500 B x 3 personsx6month)	27,000	27,000	54,000	0.2%	4%
9. Auditor fee		30,000	30,000	0.1%	2%
10.Air Ticket Fees (24000 B x 2 persons x 2 time)	96,000	96,000	192,000	0.6%	14%
11.Domestic travelling cost (5000 B x 2 x 2 time)	20,000	20,000	40,000	0.1%	3%
12.Immigration (2000 B x 9 month x 2 person)	36,000	0	36,000	0.1%	3%
13.Maintainance for Equipments (Car,Computer,Motorcycle,Others)	50,000	50,000	100,000	0.3%	7%
General Administration cost sub total	***716,000***	***665,000***	***1,381,000***	**4.5%**	***100%***
Grand total for all Program in year 2008	**16,351,220**	**14,207,030**	**30,558,250**	**100.0%**	