B.P.H.W.T Primary Health Care

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Provision of Primary Healthcare among Internally Displaced Persons and Vulnerable Populations of Burma

2011 Proposal
Back Pack Health Worker Team

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Project title:	The Provision of Primary Healthcare among Internally Displaced Persons and Vulnerable Populations of Burma
Project Programs:	A. Medical Care Program B. Community Health Promotion and Prevention Program C. Maternal and Child Health Program
Target Population: :	180,000 people living within the Mon, Karenni, Kayah, Kayan, Karen, Shan, Lahu, Kachin and Arakan areas
Project Duration:	January to December 2011
Budget requested:	**36,021,400** Thai Baht **(1,200,713.33 USD)**
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I. Overview

(i) Background on the conflict and internally displacement in Burma

Burma is one of the world's most ethnically diverse countries, home to dozens of ethnic groups. After independence in 1948, ethnic armed rebellions began to break out in the country's eastern frontier areas as groups began to press for increased autonomy. In 1962, General Ne Win overthrew the country's first parliamentary democracy, an event that would usher in almost five decades of military rule. The country's most recent military government, the State Peace and Development Council (SPDC) took power in 1998 after refusing to acknowledge the results of the democratic elections won by the National League of Democracy (NLD) under the leadership of Daw Aung San Suu Kyi. The SPDC is widely considered one of the world's most oppressive governments, due to the denial of democratic freedoms as well as widespread and systematic perpetration of human rights abuses against its own people, and particularly its ethnic minorities.

Internally Displaced Persons in Burma

Some of the ethnic armed groups signed ceasefire agreements with the ruling military regime after 1989, but armed conflict continues in many areas of eastern Burma. In areas that are contested by these organizations, the regime continues to employ the "Four Cuts" strategy. This military initiative is designed to break down the four crucial links between armed opposition groups and the people: food, financial support, recruits, and information. Such a military strategy that targets civilians is in violation of international humanitarian law. Sustained implementation of this policy has resulted in the forced relocation, destruction, or forced abandonment of over 3,600 villages and hiding sites from 1996 to 2010. Currently, there are at least 446,000 internally displaced people in the rural areas of eastern Burma alone[1].

[1] TBBC 2010 Protracted Displacement and Chronic Poverty in Eastern Burma

The Burma Army (or Tatmadaw) commits widespread human rights violations against ethnic civilians, which have been widely documented. These abuses include forced labor, confiscation and destruction of food supplies, arbitrary taxation, torture, rape and extrajudicial execution. The scale of these abuses and their ongoing and systematic nature have prompted The United Nations Special Rapporteur on human rights in Burma, Tomás Ojea Quintana, to call for a United Nations Commission of Inquiry into crimes against humanity, and war crimes in Burma. On 7th November 2010, Burma's first elections in over twenty years were held amid international criticism of a process, which has been condemned by many as neither free nor fair. Immediately after the elections, conflict has escalated by Tatmadaw forces and armed ethnic groups on the Thai-Burma border, who reject the results of the elections and refuse to lay down their arms or become part of the SDPC-controlled Border Guard Force. This increase in violence led to displacement of civilian populations either side of the Thai-Burma border and it is anticipated that the situation could get worse in the weeks and months to come.

Transporting medicines to IDP areas

(ii) The General Health Situation in Burma

Public health is another casualty of decades of military rule with chronic disinvestment in basic, essential social services. Burma's current rulers have not deviated from the negligent socio-economic policies of the past. Despite an estimated $2.5 billion trade surplus in 2009[2], predominantly from the sale of natural gas to Thailand, the regime spends around $7 per capita per year on health, amongst the lowest in the world according to the United Nations Development Program's development index[3] . Burma only spends 1.8% of total government expenditures on health, leaving Burma in 138th position in the United Nation's Development Program's Human Development Report for 2009[4]. Burma is thus lagging far behind the UN's Millennium Development Goals (MDGs).

[2] Sean Turnell 2009 Burma Isn't Broke, Wall Street Journal, August 6th.
[3] UNDP 2009 Human Development Report
[4] UNDP 2009 Human Development Report

Today, Burma's health indicators for child, infant, and maternal mortality rank amongst the worst in Asia. Burma's infant mortality rate was estimated by UNICEF at 54 per 1,000 live births, in 2009, with an under-five mortality rate of 71 in the same year[5]. These figures also suffer highly unfavorable comparisons with the infant and child mortality rates of Thailand for 2009 which were recorded as 12 and 14 respectively[6]. The main causes of morbidity and mortality in the country are overwhelmingly preventable, from disease entities such as malaria, malnutrition, diarrhea, acute respiratory illnesses, tuberculosis, and HIV/AIDS. Burma continues to register the greatest number of malaria deaths and the highest malaria case fatality rate of any country in Southeast Asia.

The health indicators for the rural ethnic populations of the east are even worse than Burma's national rates. The eastern states have been burdened by protracted low-level conflict, high levels of displacement and little to no access to state health care systems, leaving some populations of conflict zones with levels of maternal mortality of 1,000 –1,200 deaths per 100,000 live births[7].

(iii) The Health of Internally Displaced Persons:

While the health of the population of Burma is poor, the health of Internally Displaced Persons (IDPs) within Burma is a national tragedy. People who are internally displaced not only face harsh living conditions in which they struggle to survive and feed themselves; they usually have no access to existing limited health programs in Burma. In this harsh political environment, some humanitarian health assistance is being provided to internally displaced people in eastern Burma, by Non Government Organizations and Community Based Organizations, coordinated or located in Thailand. These organizations in partnership with international donors, international humanitarian organizations, and ethnic health and social organizations, deliver healthcare to internally displaced persons. Without assistance from

Providing Healthcare in IDP area

[5] United Nations Children's Fund, Level & Trends in Child Mortality, 2010
[6] Ibid
[7] Luke C. Mullany, Catherine I. Lee, Lin Yone et al. Access to Essential Maternal Health Interventions and Human Rights Violations among Vulnerable communities in Eastern Burma. PLos Medicine. December 2008.

organizations such as the BPHWT, many internally displaced people would have no access to health care.

In 2010, BPHWT published a report entitled ***Diagnosis: Critical,*** which demonstrates that a vast area of eastern Burma remains in a chronic health emergency, a continuing legacy of longstanding official disinvestment in health, coupled with protracted civil war and the abuse of civilians. This has left ethnic rural populations in the east with 41.2% of children under five acutely malnourished. 60% of deaths in children under the age of 5 are from preventable and treatable diseases, including acute respiratory infection, malaria, and diarrhea. These losses of life would be even greater if it were not for local community-based health organizations, which provide the only available preventive and curative care in these conflict-affected areas. The report summarizes the results of a large scale population-based health and human rights survey which covered 21 townships and 6,372 households in various regions including ceasefire areas, areas of oscillation political/military control, and those areas that continue to experience low-level conflict in Eastern Burma. The survey was jointly conducted by the Burma Medical Association, National Health and Education Committee, Back Pack Health Worker Team and ethnic health organizations serving the Karen, Karenni, Mon, Shan, and Palaung communities. Technical support was provided by the Global Health Access Program and the Centre for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health. These areas have been burdened by decades of civil conflict and attendant human rights abuses against the indigenous populations. Eastern Burma demographics are characterized by high birth rates, high death rates and the significant absence of men under the age of 45, patterns more comparable to recent war zones such as Sierra Leone than to Burma's national demographics. Health indicators for these communities, particularly for women and children, are worse than Burma's official national figures, which are already amongst the worst in the world. Child mortality rates are nearly twice as high in eastern Burma and the maternal mortality ratio is triple the official national figure.

Distributing Vit-A and De-worming medicines

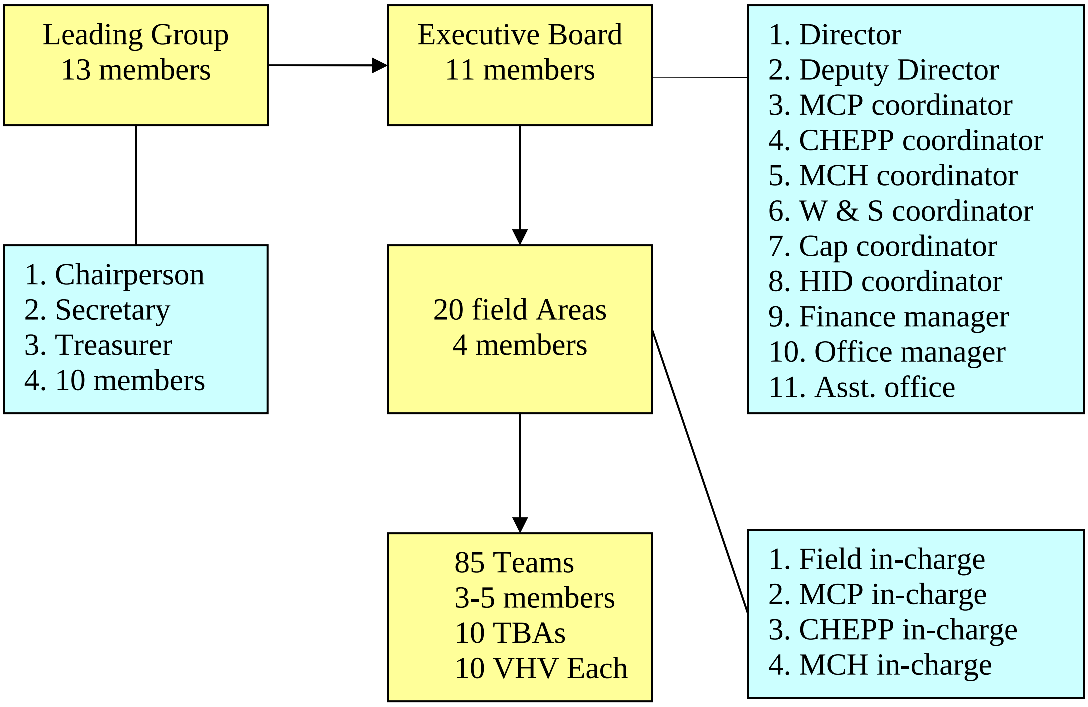
Infectious diseases are overwhelmingly the main cause of death of children and adults. Malaria accounted for almost half the deaths followed by diarrhea and acute respiratory infections. Moderate to severe malnutrition is prevalent within IDP populations, consistent with the level of malnutrition found in Africa. A water and sanitation survey conducted by the BPHWT indicated that more than 56 % rarely or never boil their water and that access to and use of latrines are low.

The estimated Maternal Morbidity Rate (MMR) within the IDP population ranks amongst the highest in the world. As most causes of maternal death are preventable within a functioning health system, this indicator is often used as a proxy for the availability of reproductive health-related care and services. According to BPHWT conducting survey, the majority of deliveries occurred at home, usually only with the assistance of a Traditional Birth Assistant (TBA), and IDP women had low levels of knowledge of the dangers of pregnancy. In unstable environments, located deep inside Burma, IDP women are more likely to deliver their baby in the jungle while hiding from the Burmese army patrols. Overall, only 4 % of IDP women had access to emergency obstetric care. Overall, both contraceptive use and access to iron supplements were low. Approximately 80% of respondents had never used contraceptives, while only 41.1% received any iron supplements during their previous pregnancy. According to the 2002 Reproductive Health survey, there is 78.2% of women unmet needs contraceptives.

Transport medicines to IDP area

II. The Back Pack Health Worker Team: The BPHWT was established in 1998 by Karenni, Mon and Karen health workers to provide health care to Internally Displaced Persons living along the eastern border of Burma, affected by over 60 years of civil war. In 2010, the BPHWT has so far provided health care in 20 field areas with 81 teams, to a target population of over 180,000 people. There are currently 1,259 health care workers connected to BPHWT living and working in Burma, comprised of 254 medics, 645 traditional birth attendants (TBAs) and 360 village health volunteers (VHVs).

(i) 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 Leading Group is comprised of 13 members, who are elected for a three years term. The Leading Group appoints an Executive Board of 11 members, which is required to meet monthly and make decisions on current issues faced by the BPHWT. The BPHWT has a range of documents that guide the leadership, management, healthcare delivery, health information systems and human resources of the organization. Full copies of any 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.

Vision: The vision of the Back Pack Health Worker Team is that of a healthy society in Burma through a primary healthcare approach, targeting the various ethnic nationalities and communities in the border areas and remote interior region of Burma.

Mission: The Back Pack Health Worker Team is organized to equip people with the skills and abilities necessary to manage and address their own healthcare problems, while working towards the long-term sustainable development of a primary healthcare infrastructure in Burma.

Goal: The goal of the Back Pack Health Worker Team is to reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare.

Financial Management and Accountability: The BPHWT has written finance policies and procedures guiding the Leading Committee, Executive Board, Coordinators and Field Staff about financial management and accountability; the production of annual finance 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) 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 the BPHWT Field Areas, based on the health access indicators.

Health Access Indicators for a Community Based Primary Health Care System

<table>
<tr><th>Population</th><th>Health Service Type</th><th>Health Workers</th><th>RATIO (workers/pop)</th><th>IDEAL Number</th></tr>
<tr><td rowspan="3">2000</td><td rowspan="3">BPHWT (Community based primary healthcare unit)</td><td>BPHWT Health Worker</td><td>1/400</td><td>5</td></tr>
<tr><td>Traditional Birth Attendant</td><td>1/200</td><td>10</td></tr>
<tr><td>Village Health Volunteer</td><td>1/500</td><td>10</td></tr>
<tr><td colspan="4">Total Health Worker Per Team</td><td>25</td></tr>
</table>

(iv) Gender Policy and Analysis: In 2010, 52 % of the people working within the BPHWT are women but it does not count on Traditional Birth Attendant. However, the organization has a gender policy which aims to improve equity for women across all levels of the organization. The table below depicts the current targets and actual percentage of women across organizational 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 in Leading Group and Executive Board.

Gender Analysis of the People Working within the BPHWT of 2010

Category	Total # of Workers	Total # of females	Females Actual %	Females Target at least %
Leading Group	13	6	46%	30%
Executive Board	11	6	55%	30%
Office staff	10	3	30%	30%
Field Management	56	19	34%	30%
Field Health Workers	198	96	49%	30%
Traditional Birth Attendants	645	572	89%	**Target not set**
Village Health Volunteers	360	205	57%	30%
Total Organization	**1293**	**907**	70%	**Target not set**
Total Organization without TBAs			52%	30%

III. BPHWT Programs

The Back Pack Health Worker Team aims to improve health through the delivery of primary healthcare and public health promotion. The BPHWT provides Medical Care, Community Health Education and Prevention and Maternal, Child Healthcare and Water and Sanitation Programs in their target area. Integrated through these primary healthcare programs, are the Health Information and Documentation and the Capacity Building Programs.

(i) Medical Care Program (MCP): Over the last 10 years the most common diseases treated by the BPHWT have been malaria, acute respiratory infections (ARI), worm infestation, anemia and diarrhea. In 2009 the BPHWT treated 88,786 cases, and by mid year 2010, they had treated 46,153 cases. All data from the field is carried back to the office by the health workers, as they come to attend the six monthly meetings of the BPHWT. The BPHWT teams follow the treatment protocols outlined in the Burmese Border Guide Lines. The Health Information and Documentation Program, collects and analyses the health data and short courses for health workers, delivered by international consultants forms the main content of the capacity building in the Medical Care Program.

MCP objectives:

- Provide essential drugs and treat the common diseases
- Respond to disease outbreaks and emergency situations
- Improve health workers' skill and knowledge
- Improve patient referral systems

MCP activities

- Provide medicine and medical supplies and treat common diseases and minor injuries
- Purchase emergency medical supplies and immediately take action
- Organize field workshops, 6 month workshops and short course trainings
- Refer patients to the near hospitals or clinics

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

The CHEPP aims to enable and empower the internally displaced and vulnerable communities, with skills and knowledge related to basic primary health care concepts to improve hygiene, water supplies, sanitation systems, nutrition and other health related issues. Capacity building through peer education training in schools, Village Health Workshops and the Village Health Volunteers sub-program provides the community with the health knowledge to be able take independent measures to improve hygiene conditions, develop water and sanitation systems, improve nutrition, prevent and control communicable disease of Lymphatic Filariasis and manage basic health care. The program also distributes Vitamin A and de-worming medication; builds safe water supplies and constructs latrines.

Providing Well in Papun Area

CHEPP objectives:

- Reduce the incidence of malnutrition and worm infestation
- Educate students and communities about health
- Improve community level knowledge and participation in health

- Improve water and sanitation systems in the community to reduce water-borne diseases
- Prevent and control communicable disease of Lymphatic Filariasis

CHEPP Activities:

- Distribute Vitamin A to children between the ages of 6 months to 12 years and anti-helminthes to children between ages 1 to 12 years
- Provide school health education, village health workshops and health campaigns
- Organise Village Health Volunteer training and workshop
- Provide Water and Sanitation system
- Providing Mass Drugs Administration among the community and educating community members about Lymphatic Filariasis

(iii) Maternal and Child Health Care Program (MCHP): In Maternal and Child Health Care Program, capacity building is delivered through the 48 hours TBAs Training Course, 20 days level 2 TBA training and 3 days TBAs Field Workshops every six months in field areas. TBA follow-up workshops are held throughout the fields in every six months as well. The BPHWT has the criteria to recruit new TBAs; the TBAs who will work in this program need to have experience of delivering at least 5 babies and have attended twice TBA workshops. Additionally, they have to be recommended by the communities. As a result, the TBAs who are working in MCH program already have experience of delivering 5 babies ore more.

Provide healthcare to a mother

Also through the 6 monthly Reproductive Health Workshop which is attended by Maternal and Child Health (MCH) Supervisors. 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.

MCHP objectives:

- Increase maternal and child healthcare
- Encourage positive community attitudes towards, and utilization of, family planning
- Improve the knowledge and skill of TBAs and MCHP supervisors

- Provide delivery records

MCHP activities:

- Distribute Vitamin A and iron tablet prenatally and postnatally and Albandazole prenatally to pregnant women
- Provide family planning supplies
- Conduct TBA training, provide safe birthing kits and conduct TBA Field and Reproductive Health workshop
- Document deliveries

(IV) Integrated Capacity Building program: The Back Pack Health Worker Team (BPHWT) has organized short training courses in order to upgrade health worker's skills and knowledge; the BP field in-charges, field MCH supervisors, TBAs trainers, other BP health workers and inviting the technical consultants from international NGOs. The BPHWT also organizes community health worker and refresher training courses, which collaborates with local health organizations.

Capacity building objectives:

- To improve management skill, clinical skills, knowledge and concept of primary health care for the health workers.
- To promote the management skills of office staff.
- Exchange current and updates on health information to the Back Pack Health workers.
- Recruit new health workers
- Promote gender equality in leading positions

Capacity building activities:

- Conduct the short training courses of management skills and capacity for office staff.
- Conduct short training courses and training of trainer that relate with program's activities
- Organize Community Health Worker training and collaborate with local health organizations.
- Participate in other local health seminars and international health conferences.
- Organize health trainings with local health organizations
- Provide management skill trainings to women

(V) Health Information and Documentation: The BPHWT collects health information and documents evidence of the health situation and assess the community needs in eastern Burma. This integrated program also plays a role in monitoring and evaluation of the programs. The BPHWT conducts health needs annually and impact assessment surveys every tow years, to compare and evaluate the annual program outcomes. Documentation includes photos, videos and written reports.

HID objectives:

- Assess and document community health situation and needs
- Standardize health data collection processes
- Make evidenced based health status comparisons among the target community
- Raise awareness of the community health problem
- Advocate local and international organizations about the health situation in Burma

HID activities:

- Conduct community needs assessment surveys and provide HID materials
- Analyse data collected by BPHWT health workers
- Organize training and/or workshops aimed at standardizing case-definition data collections
- Produce health information, education, and communication materials for Village Health Workshops
- Organize a Health Program Coordination and Development Seminar, and prepare health-related abstract papers and presentations to deliver at local and international seminars

Health Indicators	Target Group	Measurement Tool
1. Malaria Morbidity Rate	Entire population	Annual data analysis and Program Impact Assessment Survey within 2 years (2010)
2. ARI Morbidity Rate	Entire population	Annual data analysis
3. Dysentery and Diarrhea Morbidity Rates	Entire population	Annual data analysis and Program Impact Assessment Survey within 2 year s (2010)
4. Child Mortality Rate	Children under 5 years and infant	Program Impact Assessment Survey within 2 years (2010)
5. Number of pregnant women receiving Iron supplements	Pregnant women	Annual analysis of iron supplement data
6. Number of TBAs practicing clean birthing methods	Traditional Birth Attendants	TBA assessment survey
7. Coverage of anti-helminthes distribution	Children 1 to 12 years	Annual analysis of de-worming data
8. Coverage of Vitamin A distribution	Children under 12 years	Annual analysis of Vitamin A data and Program Impact Assessment Survey within 2 years (2010)
	Pregnant women	Annual analysis of Vitamin A data
9. Percentage of people who have and use latrines	Entire population	Program Impact Assessment Survey within 2 years (2010)
10. Number of community participation in workshop	Entire Population	Annual Analysis of participants in workshop
11. Number of students participation in school health	Students	Annual analysis of number students data
12. Percentage of mothers who give ORS to children who have diarrhea	Women with children who have diarrhea	Program Impact Assessment Survey within 2 years (2010)
13. Maternal Mortality Ratio	Women during pregnancy and up to 42 days post delivery	Annual analysis of TBA data and Program Impact Assessment Survey within 2 years (2010)

Key health Indicators

IV. Coordination and cooperation: 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 twenty 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.

V. Map of Operation areas

VI. Logical Framework of BPHWT program in 2011: The BPHWT programs and describes the activities, indicators of achievements, verification sources, expected outcomes and the risks involved in the delivery of the programs.

Overall goal	**To reduce morbidity & mortality & minimize disability by enabling & empowering the community through primary health care**						
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**2011 EXPECTED Results**	**2011 Actual Results**	**Variances or differences**	**RISKS**
Medical Care Program							
1. Provide essential drugs and treat the common diseases	- Provide medicine and medical supplies - Treat common diseases and minor injuries - Trauma Care Unit - Provide ITNs - Provide ACT to patients with malaria	- No of target population and total case-load (f/m), under/over 5) - No villages covered - No of treated Trauma cases - No of HH receiving ITNs - Percentage of people sleeping under ITNs - No of ACT provided	- Procurement delivery documents Log books - Analysis of data collected - Form A - Impact assessment survey 2012 (71% in 2010) - Malaria data form	- 180,000Targeted population - 85,000 cases being treated (no of families & HH, no of f/m and under/over 5 , no of villages covered) - 150 Trauma cases treated - 5,000 ITNs will benefit to 25000 population - 80% people sleeping under ITNs (2012 impact assessment survey) - 8,000 ACT will be provided			- Insufficient funding - Medical supplies stolen by SPDC - Data lost, stolen or incomplete
2. Respond to disease outbreaks and emergency situations	- Purchase emergency medical supplies and immediately take action	- Prompt reporting - Population affected - No of cases treated (f/m, under & over 5)	- Delivery documents - Field photos - Exceptional reports - Mid year & Annual Reports	- Effective response and treatment for disease outbreaks or emergency situations (f/m & under/over 5)			- Delay in field reporting outbreak or emergency - Hostile military activity delays or prevents mobilization
3. Improve Health Workers skills and knowledge	- Provide Field workshops - 6 month workshops - Short course training	- No of Health Workers participated -% of Improving diagnosis & treatment - percent of health worker who receive a	- Field reports - Workshop reports - Log book review & analysis - Mid year & Annual Reports	- 170 attend Field Workshops - 80 health workers attend 6 month workshops(f/m)			- High risk travel due to security issues

		score of at least 95 % in post-test (M/f)					
4. Improve patient referral systems	- Refer patients to the near hospitals or clinics.	- No of referrals - list of refer site - No of f/m referral patients	- Mid year & Annual Reports -Patient's referral form	- 70 patients referred to clinics or hospitals (f/m)			- High cost of transporting patients - High cost of medical care at referral sites
Community Health Education and Prevention Program							
1. Reduce the incidence of malnutrition and worm infestation	-Distribute de-worming medicine to children between 1 to 12 years - Distribute Vitamin A to children between the ages of 6 months to 12 years	- No of children receiving Vitamin A - No of children receiving de-worming medicine	- Worker Data form and Six monthly report	- 40,000 children will receive de-worming medicine - 35,000 children will receive Vit - A			
2. Educate students and communities about health	- Provide school health education - Provide village health workshops - Provide health campaign	- No of school sessions and no of students (f/m) - No & category of people in village workshops (f/m) - No of people participate in event (f/m) (World AIDS day)	- Field reports - Mid year & Annual Reports - VH workshop reports	- 85 school sessions attended by 8500 (m/f) - 11,900 people participate in 85 sessions Village Health Workshops - Breakdown of participants by category (women, youth, TBA, VHV, shopkeepers. leaders, teachers etc) (f/m) - 85 World AIDS events for 12750 people			- Time limitations of community members
3. Improve community level knowledge and participation in health	- Organize village health volunteer trainings and workshops - Provide VHV kits	- No training sessions and VHV attended (f/m) - No workshop sessions and VHV participated - Ratio of VHV to target population - No of VHV kits provided	- Field reports - Mid year & annual reports - VHV training and workshop report	- 15 VHV trainings for 300 new VHVs (f/m) - 155 sessions of VHV workshop for 3,100 VHVs (f/m) - 500 VHV kits will be provided			- Participant Turnover attending the workshop

4. Improve water and sanitation systems in the community to reduce water-borne diseases	- Provide water and sanitation systems	- # & type of latrines built and # of HH and people benefit from latrines - # & type of water systems installed -# of HH and people benefit from water systems (f/m) - % of people using latrines (always and sometimes)	- Field reports - Mid year & Annual Reports - Impact assessment survey 2012 (98%-2010)	- 800 school latrines will be benefited 17000 students - 5000 community latrines or will be benefited 50000 pop; - 20 gravity flow water systems 1200 house-holds (6000 Pop) - 100 shallow well systems 1000 house-holds (5000 pop) - 98% of people using latrines			- Insufficient funding - Hostile military activity prevents transportation and installation
5. Prevent and control communicable disease of Lymphatic Filariasis	- Provide Mass Drugs Administration for among the community - Educate community members about Lymphatic Filariasis	- No of people receive drug (f/m & under/over 5) - Provide awareness workshop - Provide ICT test	- field report - mid-term report - No of participants - No of ICT test provided	- 13,100 people will receive Albandazone and DEC. (f/m and under/over 5) - 5 sessions of awareness workshop to 1500 (f/m) population - 900 ICT test			- Community complain on side-effect - security concern
Mother and Child Health Care Program							
1. In crease maternal and child healthcare	- Distribute Vitamin A and Albandazole - Provide iron prenatally and postnatally pregnant women - Refer of serious obstetric cases	- No of pregnant women receiving Vitamin A and Albandazole - No of pregnant women receiving iron - No of serious obstetric cases	- TBA's form	- 4,000 pregnant women will receive Vit-A and Albandozole - 3,300 pregnant women will receive iron - 20 obstetric cases refer			- Security issues can affect data level returned

2. Raise awareness among villagers on family planning and provide them with family planning supplies	- Provide family planning supplies	- No of clients receive the family planning supplies (f/m)	- Mid year & Annual Reports	- 3,500 people using family planning methods (f/m)			- Traditional cultural barriers
3. Improve knowledge & skills of TBAs & MCH Supervisors	- Conduct TBA training - Conduct level 2 TBA training - Conduct TBA field and reproductive health workshops - Provide safe birthing kits	- No of new TBAs - No of new TBAs complete the training - No of TBA Follow-up Workshops held & no of TBAs attending (f/m) - No of Reproductive Health Workshops held & no of MCH Supervisors attending (m/f) - Percent of TBA who receive a score of at least 85% on the post-test - No of births attended by trained TBAs and health workers, among total target population - No of TBA kits provided - No of Maternity Kits provided -Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010 - Povidine/ Iodine or other antiseptic = 354	- Workshop reports - Field reports - Field photos - Mid year & Annual Report - TBAs' form - mid-term and annual report - TBA assessment	- 5 sessions of TBA training attended by 50 new TBAs (f/m) - 1 session of level 2 TBA training for 30 people (f/m) - 70 Follow-up TBA Workshops for 700 (f/m) TBAs - 2 RH Workshops attended by 25 MCH supervisors - 4000 pregnant women delivery by TBAs and health workers - 1,480 TBA kits - 5,800 maternity kits - Appropriate sterile instrument (new razor blade, sterile scissors, etc) 85% Povidine/ Iodine or other antiseptic 90%			- Security issues affect travel - Traditional cultural barriers

		(85%)-2010 - At the last pregnancy that you delivered provide at least 3 information = 353 (85%) -2010		-At the last pregnancy that you delivered provide at least 3 information 90%			
4. Provide delivery records	- Document deliveries	- No of new born baby received Delivery record	- Delivery record issues copies	- 2,000 delivery records			- Security concern - Traditional cultural barriers
Capacity Building							
1. Improve health Worker and staff knowledge and skills	- CHW TOT training - CHW training - Medical Refresher training course -First Aid training, first aid kits & hand books - Trauma care workshop - Attendant international conference and training	- No of CHW attend the TOT training (f/m) - No of trainees completed CHW training (f/m) - No of trainees complete medical refresher course training (f/m) - No of participants in First Aid training (f/m) - No of first aid kits provided - No of people participate in Trauma care workshop - No of times participation in conference and training	-Training report - Attendant list	- 1 CHW TOT for 20 CHW - 3 CHW trainings for 90 CHW (f/m) - 2 refresher course training for 60 medics (f/m) - 85 First Aid training for 1700 people (f/m) - 850 First Aid kits & 600 hand book provided - 1 Trauma care workshop for 20 people - 2 international and 6 local conferences or trainings			- Security concern affected in training location - Resettlement - traveling document
2. Promote gender equality in leading positions	- Provide management skill trainings to women	- % of women leading health programs - % of women field in-charges - % of women in leading committee	Staff lists	- At least 30% of women leading health programs - At least 30% of women field-in charge - At least 30% of women in leading committee			

Health Information and Documentation							
1. Assess and document community health situation and needs	- Conduct community needs assessment - Produce HID materials	- No of BP teams, no of villages, no of HH provided assessment - No of CDs produced - No of calendars and no of article reports provided	- Field in-charge report - HID staff report	- 85 BP teams, 600 villages and 35,000 HHs - 500 CDs provided - 1,000 calendars, and 5 article reports provided in a year			
2. Standardize health data collection processes	- Analyze data collected by health workers	- Times of workshop - No of participants	- Six months Workshop report form	- Twice a year - 10 participants each time.			
3. Make evidenced based health status comparisons among the target community	- Organize meetings and workshops	- No of meetings or workshops provided - No of participants	- Field workshop report	- Twice a year - 70 people participate in workshop or meeting			
4. Raise awareness of the community health problem	- Produce health information, education and communication materials	- No of IEC materials provided - No of participants	- IEC distributing list - VH workshop report form	- 2,550 IEC materials will provide (at least 3 categories) - 15,000 participants			
5. Advocate local and international organizations about the health situation in Burma	- Organize health program coordination and development seminar and prepare abstract papers	- No of seminar - No of abstract papers produced	- Annual year report	- At least once a year - 4 abstract papers relate health issues produced			
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	- Conduct monitoring trip - Conduct six months meeting - Provide Leading Group meeting - Provide Executive Board meeting once in a month - Provide staff meeting weekly	- No monitoring trips and no of staff - No of health workers attend the six months meeting - No of Leading Group meeting provided - No of Executive Board meeting provided - No of staff meeting provided	- mid & annual report	- 3 monitoring trips in a year - 100 health workers attend the six months meeting - 2 Leading Group meeting per year - 12 Executive Board meeting per year - 48 staff-meeting per year			

VII. Program Activity Time Lines: Though many BPHWT activities can be disrupted by the military activity of the SPDC and their allied armies, the table below provides the planned implantation timelines for activities.

Program Activity Time Lines

ACTIVITIES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Medical Care Program												
1. Provide medicine and Medical supplies	√	√	√	√	√	√	√	√	√	√	√	√
2. Treat common diseases and minor injuries	√	√	√	√	√	√	√	√	√	√	√	√
3. Collect caseload information, pop information	√						√					
4. Trauma care unit			√	√	√	√	√	√	√	√	√	√
5. Provide ITNs			√	√					√	√		
6. Provide ACT to patients with malaria	√	√	√	√	√	√	√	√	√	√	√	√
7. Purchase emergency Medical supplies		√					√					
8. Field Meetings	√						√					
9. Village Health Workshop			√	√					√	√		
10. 6 monthly meetings/workshop		√						√				
11. field workshop			√						√			
12. Short courses training			√							√		
13.Refer patients to the near hospitals or clinics	√	√	√	√	√	√	√	√	√	√	√	√
Community Health Education and Prevention Program												
1. Distribute de-worming medicine and Vitamin A to children			√	√					√	√		
2. student personal hygiene sessions						√					√	

3. Health campaign				√	√					√	√	
4. Village Health Workshops				√	√					√	√	
5. VHV Training Sessions				√	√							
6. Distributing VHV kits				√						√		
7. VHV Workshops				√						√		
8. Build school & community latrines			√	√					√	√		
9. Build gravity flow & shallow well water systems			√	√					√	√		
10. Mass-drugs administration provided			√	√					√	√		
11.Conduct LF awareness workshop		√						√				
Maternal and Child Health Care Program												
1. TBA training			√	√								
2. Level 2 TBA training									√	√		
3. TBA meeting				√	√							
4. TBA workshop			√	√					√	√		
5. providing TBA Kits and Maternity Kits			√	√					√	√		
6. Vit-A and Albandazole distributed to pregnant women			√	√					√	√		
7. Iron distributed prenatally and postnally			√	√	√	√			√	√	√	√
8. Refer of serious obstetric cases	√	√	√	√	√	√	√	√	√	√	√	√
9. Family planning supplies provided			√	√	√	√			√	√	√	√
10. Reproductive Health Workshops held		√						√				
11. Document and issue delivery record	√	√	√	√	√	√	√	√	√	√	√	√
Capacity Building												
1. Organize community health worker training						√						
2. Organize CHW TOT		√										

3. Organize refresher course for senior medics			√	√	√	√	√	√	√	√		
4. Organize First Aid training			√	√					√	√		
5. Organize Trauma care workshop		√										
6. attendant local and international conference and training					√	√			√	√		
Health Information and Documentation												
1. Conduct community need assessment	√	√				√	√					
2. Provide HID materials	√	√				√	√					
3. Analyze data collected by health worker	√	√				√	√					
4. Organize meetings and workshops	√	√				√	√					
5. Provide health information and communication materials	√	√				√	√					
6. Organize health program coordination and development seminar and prepare abstract papers	√	√				√	√					
Program Management and Evaluation												
1. Conduct monitoring trips			√	√					√	√		
2. Conduct six months meeting	√						√					
3. Organize Leading Group meeting	√						√					
4. Organize Executive Board meeting	√	√	√	√	√	√	√	√	√	√	√	√
5. Organize weekly staff meeting	√	√	√	√	√	√	√	√	√	√	√	√

VIII. Management, Monitoring and Evaluation

(i) Organisational Management and Development: There are a range of documents that guide the management of the BPHWT and the table below gives a summary of the internal reporting framework. 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.

The Back Pack Health Worker Team organizes program activities meetings twice a year and a general meeting once a year. The meetings include a section on monitoring and evaluation. In 2007, the BPHWT carried out the process of Internal Programming Improvement Project (IPIP) in order to evaluate the improvement of the activities and particularly focused on Quality Control (Drug and Health workers' skills), Logistic Management, Office/Program Administration and improvement of women participation; this IPIP have changed to Internal Program Monitoring Team (IPMT) in the 19th, six month and 2nd term of leading Group meeting in 2008.

In August 2010, BPHWT conducted a Strategic Planning Workshop, with support from BRC and involving field and management staff in the identification of strengths, weaknesses and future priorities for the organisation. In August 2010, an external evaluation of BPHWT's programs and management systems was initiated by an external consultant in partnership with BPHWT management; the results of the evaluation will be shared with donor and partner organisations in 2011.

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-charges 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 members	- 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

(ii) Program Monitoring and Evaluation: The BPHWT undertakes a range of monitoring and evaluation activities, some of which a conducted by external consultants or organisations. The table below summarises the current Monitoring and Evaluation framework.

Topic	Method	Participants	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	Calculating morbidity rates of common diseases	- Executive Director - HIS staff - Program Coordinators	Annually	Morbidity rates over time included in the Annual Report
Improving health outcomes	Impact Assessment	- Survey team	Two yearly	Impact assessment included in the corresponding Annual Report
Financial management	Comparison of budget & actual income & expenditure Financial Audit	- Leading Group - Fields-in-Charge	6 monthly	Comparison and explanation of variances included in the 6 monthly and Annual Reports
Satisfaction with organizational management	Election of Leading Group	- External Auditing Firm - Director - Finance Manager - Accountant - All BPHWT members	Annually Three yearly	Audited Financial Report included in the Annual Report Outcome of elections included in corresponding Annual Report

IX. Budgeting (January to December 2011)

Items	Jan-Jun 11	Jul-Dec 11	Total	% Total Budget	% by program
I. Medical Care Program (MCP)					
A) MCP program operation cost					
1. Program coordinator operation cost (7000 B x 6 mths x 1 person)	42,000	42,000	84,000		1%
2. Program staff operation cost (4,000 B x 6 mths x 1 person)	24,000	24,000	48,000		0%
MCP program operation cost sub total	**66,000**	**66,000**	**132,000**		**1%**
B) MCP Activities and supplies					
1. General Medicine & Medical supplies (23,000B x 85 BPs)	1,955,000	1,955,000	3,910,000		31%
2. Malaria Medicine supplies (15,000B x 85 BPs)	1,275,000	1,275,000	2,550,000		21%
3. Malaria rapid test (40 B x 150 x 85 BPs)	510,000	510,000	1,020,000		8%
4. Mosquito net (150 B x 5000 + 5000)	750,000	750,000	1,500,000		12%
5. Medicine transportation (3,000 B x 85 BPs)	255,000	255,000	510,000		4%
6. MCP worker's operation cost (1,200 B x 6 mths x 85 persons)	612,000	612,000	1,224,000		10%
7. Field-coordinator operation cost (1500 B x 6 mths x 20 persons)	180,000	180,000	360,000		3%
8. Emergency medical supplies	400,000	400,000	800,000		6%
9. Treatment Hand Book (150 B x 500 Books)	75,000	0	75,000		1%
10. Report form	10,000	10,000	20,000		0%
11. Log book	15,000	15,000	30,000		0%
12. Malaria medicine and supplies for health centre (15,000 B x 6 centers)	9,0000	9,0000	180,000		1%
13. Malaria rapid test for health centre (40 B x 150 x 6 centre)	36,000	36,000	72,000		1%
14. Trauma Care Unit (30,000 x 3 unit)	90,000		90,000		1%
MCP Activities and supplies cost sub total	**6,253,000**	**6,088,000**	**12,341,000**		**99%**
MCP Sub Total	**6,319,000**	**6,154,000**	**12,473,000**	**34.6%**	***100%***
II. Community Health Education and Prevention Program (CHEPP)					
A) Program Operation Cost					
1. Program coordinator operation cost (7,000 B x 6 mthsx 2 persons)	84,000	84,000	168,000		2%
2. Program staff operation cost (4,000 B x 6 mths x 1 person)	24,000	24,000	48,000		1%
3. CHEPP Workers operation cost (1200 B x 6 mths x 85 persons)	612,000	612,000	1,224,000		15%
4. Field coordinator operation cost (1500 B x 6 moths x 20 fields)	180,000	180,000	360,000		4%

Program operation cost sub total	**900,000**	**900,000**	**1,800,000**		**22%**
B) 1. Village Health Volunteer Training/Workshop					
1. Village Health Volunteer Training (25,000 B x 15 training)	375,000		375,000		4%
2. Village Health Volunteer workshop (2000 B x 70 + 85 sessions)	140,000	170,000	310,000		4%
3. VHV kits (300 B x 500 kits)	150,000	150,000	300,000		4%
VHV Training/workshop sub total	***665,000***	***320,000***	***985,000***		**12%**
C) School Health Promotion					
1. Personal hygiene (20 B x 100 students) x 85 BPs	0	170,000	170,000		2%
2. Latrine (500B x 10 x 80 sessions)	0	400,000	400,000		5%
3. Health Camping event (2,000 B x 85 BPs)	0	170,000	170,000		2%
School Health Promotion sub total	**0**	**740,000**	***740,000***		**9%**
D) Village Health Workshop (3000 B x 85 session)	**255,000**	**255,000**	***510,000***		**6%**
E) Water & Sanitation					
1. Gravity flow water system (35,000 B x (10+10) sessions	350,000	350,000	700,000		8%
2. Shallow well water system (5,000 B x (50 +50) sessions	250,000	250,000	500,000		6%
3. Community Latrine (500B x 2500 +2500 latrines)	1,250,000	1,250,000	2,500,000		30%
Water & Sanitation sub total	***1,850,000***	***1,850,000***	***3,700,000***		**45%**
F) Nutrition Promotion					
1. Vitamin A distribution (3 B x 40,000 + 40,000)	120,000	120,000	240,000		3%
2.De-worming for mebendazole (1.5 B x 35,000 + 35,000)	52,500	52,500	105,000		1%
Nutrition promotion sub total	**172,500**	**172,500**	***345,000***		**4%**
G) Communicable disease Control (Filiariasis)					
1. DEC (48,500 tabs + 30,000 tabs)x 2.4B	116,400	72,000	188,400		2%
2. Albendozole (28,000 tabs x 10,000 tabs)2.0B	56,000	20,000	76,000		1%
3. ICT Test (900 x 70 B)	63,000	-	63,000		1%
4. Awareness workshop (2000 B x 5sessons)	10,000	-	10,000		0%
5. Personal Operation cost (1200 B x 6 mths x 5 staffs)	36,000	36,000	72,000		1%
Communicable disease Control (Filiariasis Pilot Program)sub total	**281,400**	**128,000**	**409,400**		**5%**
H) IEC materials					
1. Poster and Pamphlet	35,000	35,000	70,000		1%

IEC materials sub total	**35,000**	**35,000**	**70,000**		**1%**
CHEPP Sub total	***4,158,900***	***4,400,500***	***8,559,400***	**23.7%**	***100%***
III. Maternal and Child Health Program (MCHP)					
A) Program Operation Cost					
1. Program coordinator operation cost (7,000 Bx 6 mths x 2 persons)	84,000	84,000	168,000		2%
2. Program staff operation cost (4,000 B x 6 mths x 1 person)	24,000	24,000	48,000		1%
3. MCH workers operation cost (1,200 B x 6 mths x 85 persons)	612,000	612,000	1,224,000		15%
4. Field coordinator operation cost (1,500B x 6 mths x 19 person)	171,000	171,000	342,000		4%
5. Special Trained TBA curriculum development	10,000	0	10,000		0%
6. STTBA Curriculum (hand book) 500 x 70 B	35,000	0	35,000		0%
MCHP program operation cost sub total	***936,000***	***891,000***	***1,827,000***		**37%**
B) TBA Training short course (7 days)					
1. Food (50 B x 12 persons x 7 days x 5 sessions)	21,000	0	21,000		0%
2. TBA Kit (400B x 10 TBAs x 5 sessions)	20,000	0	20,000		0%
3. Maternity Kit (150 B x 4 mothers x 10 TBAs x 5 sessions)	30,000	0	30,000		0%
4. Stationary and documentation (1,000B x 5 sessions)	5,000	0	5,000		0%
5. TBA and Maternity kit transportation (1,500 B x 5 sessions)	7,500	0	7,500		0%
6. TBA Compensation (500B x 10 TBAs x 5 sessions)	25,000	0	25,000		0%
MCHP TBA training sub total	***108,500***	***0***	***108,500***		**2%**
C) TBA Workshop					
1. Food (50 B x12 persons x 3 days x 70 sessions)	126,000	126,000	252,000		3%
2. TBA Kit (400 B x 10 TBAs x 70 sessions)	280,000	280,000	560,000		7%
3. Maternity Kit (150 B x 4 mothers x 10 TBAs x 70 sessions)	420,000	420,000	840,000		10%
4. TBA and Maternity kit transportation (1500 B x 70 sessions)	105,000	105,000	210,000		3%
5. Stationary (500B x 70 sessions)	35,000	35,000	70,000		1%
6. TBA compensation (500B x10 TBAs x 70 sessions)	350,000	350,000	700,000		8%
MCHP Follow-up workshop sub total	***1,316,000***	***1,316,000***	***2,632,000***		**53%**
Level 2 TBA Training					
1. Food (50 B x30 persons x 20 days x 1sessions)	*0*	*30,000*	*30,000*		0%
2. TBA Kit (400 B x 30 TBAs x 1sessions)	*0*	*12,000*	*12,000*		0%

3. Stationary and documentation (5,000 B x 1 sessions)	*0*	*5,000*	*5,000*		0%
4. TBA compensation (500B x 30 TBAs x 1sessions)	*0*	*15,000*	*15,000*		0%
5. Distance transportation (3,000 B x 30 Persons)	*0*	*90,000*	*90,000*		1%
6. Local transportation (5,000 B x 1 session)	*0*	*5,000*	*5,000*		0%
7. Security cost (5,000 B x 1session)	*0*	*5,000*	*5,000*		0%
Level 2 TBA Training	***0***	***162,000***	***162,000***		**3%**
D) Delivery record	***30,000***	***0***	***30,000***		**1%**
E)Family Planning	***80,000***	***80,000***	***160,000***		**3%**
F) TBA meeting					
1) Stationary and documentation (1000 Bx20feidls)	20,000	20,000	40,000		1%
2) Food and supplies (60,000 B x 20 fields)	120,000	120,000	240,000		4%
3) Transportation (3000 B x 20 fields)	60,000	60,000	120,000		2%
TBA meeting sub total	***200,000***	***200,000***	***400,000***		**8%**
MCHP Follow-up workshop sub total					
MCHP Sub Total	***2,670,500***	***2,649,000***	***5,319,500***	***14.8%***	***100%***
IV. Capacity Building Program (CBP)					
A) Capacity Building					
1. CHW training (300,000 B x 2+1 training)	600,000	300,000	900,000		30%
2. Refresher course for Junior medic -30 medics (300,000 x 1 + 1 Terms)	300,000	300,000	600,000		20%
3. International Conference and Training	250,000	250,000	500,000		17%
4. CHW TOT Training 1 course	150,000		150,000		5%
5. Training monitoring & evaluation	50,000		50,000		2%
6. TOT For MCH Supervisor	30,000		30,000		1%
CBP Sub total	**1,380,000**	**850,000**	**2,230,000**		**75%**
) First Aid training					
1. First Aid Training (2,500 B x 40 +45 BPs)	100,000	112,500	212,500		7%
2. First Aid Kit (300 B x 850 trainees)	255,000		255,000		9%
3. Fist Aid training hand-book	30,000		30,000		1%
First Aid training sub total	**385,000**	**112,500**	**497,500**		**17%**
C) Trauma care workshop (					

1) food (100 B x 20 persons x 7 days 1 session)	14,000		14,000		0%
2) Stationary and teaching aid (6000 B x 1 session)	6,000		6,000		0%
3) Basis need supplies (500 B x 20 persons x 1 session)	10,000		10,000		0%
4) Transportation (3000 B x 20 persons x 1 session)	60,000		60,000		2%
5) Local transportation	5000		5000		0%
6) Security cost	5000		5000		0%
Trauma care workshop sub total	***100,000***		***100,000***		***3%***
D) Health Program Coordination and Development Seminar					
1. Food (100 B x 70 x 3 days)		21,000	21,000		3%
2. Stationary & Documentation		6,000	6,000		1%
3. Local transport & Security expends		10,000	10,000		1%
4. Distance transportation		100,000	100,000		7%
5. Data management and Documentation training		25,000	25,000		3%
Health Program Coordination and Development Seminar Sub total		**162,000**	**162,000**		**5%**
Capacity Building Program sub total	***1,865,000***	***1,124,500***	***2,989,500***	**8.3%**	***100%***
V. Health Information and Documentation (HID)					
A. Health Information & Documentation					
1. Program coordinator operation cost (7,000 Bx 6 mths x 1person)	42,000	42,000	84,000		12%
2. Still digital camera (6000 B x 10+10 digitals camera)	60,000	60,000	120,000		17%
3. Photo Development	10,000	10,000	20,000		3%
4. Video Camera (30,000 x 1 + 1 camera)	30,000	30,000	60,000		9%
5. Memory stick and video tape	25,000	25,000	50,000		7%
6. Publication (Calendar)	70,000	0	70,000		10%
7. Publication (T-Shirt 150 x 500)	75,000	75,000	150,000		21%
8. Communication Equipment	50,000	0	50,000		7%
9. Special and Article report	50,000	50,000	100,000		14%
Health Information and Documentation Sub total	**412,000**	**292,000**	**704,000**		**100%**
HID Sub total	***412,000***	***292,000***	***704,000***	**2.0%**	***100%***
VI. Program Management and Evaluation					
A) Program managing cost					

1. Leading members Compensation (7,000 B x 5 persons x 6 mths)	210,000	210,000	420,000		12%
2. Director stipend (7,000 B x 1 person x 6 mths)	42,000	42,000	84,000		3%
3. Deputy director stipend (7,000 B x 1 person x 6 mths)	42,000	42,000	84,000		3%
4. Treasurer stipend (42,000 B x 1 person x 6 mths)	42,000	42,000	84,000		3%
5. Finance manager stipend (7,000 B x 1 person x 6 mths)	42,000	42,000	84,000		3%
6. Accountant stipend (4,000 B x 1 person x 6 mths)	24,000	24,000	48,000		2%
Program managing cost sub total	***402,000***	***402,000***	***804,000***		**24%**
B. Six monthly meeting and 3 main programs workshop					
1. Food (80 B x 100 persons x 28 days)	224,000	224,000	448,000		14%
2. Stationary and documentation	35,000	35,000	70,000		2%
3. Local transportation	30,000	30,000	60,000		2%
4. Security cost	20,000	20,000	40,000		1%
5. Distance transportation (3,000 B x 100 persons)	300,000	300,000	600,000		19%
6. Personal effect while in Mae Sod (500 B x 100 persons)	50,000	50,000	100,000		3%
7. Decoration	5,000	5,000	10,000		0%
Six monthly Meeting and 3 main programs workshop sub total	***664,000***	***664,000***	***1,328,000***		**42%**
C) Field Meeting and Workshop					
a. Field Meeting					
1. stationary and documentation (1,000 B x 20 fields)	20,000	20,000	40,000		1%
2. Food and supplies (6,000 B x 20 fields)	120,000	120,000	240,000		8%
3. Field Coordination & Communication fees (1500 x 20 fields)	30,000	30,000	60,000		2%
4.Transportation (3,000 B x 20 fields)	60,000	60,000	120,000		4%
Field Meeting sub total	***230,000***	***230,000***	**460,000**		**14%**
b. Field Workshop					
1.Stationary and documentation (1,000 B x 20 fields)	20,000	20,000	40,000		1%
2.Food and supplies (5,000B x 20 fields)	100,000	100,000	200,000		6%
3.Transportation (3,000 B x 20 fields)	60,000	60,000	120,000		4%
Field workshop sub total	**180,000**	**180,000**	**360,000**		**11%**
D) Program Monitoring and Evaluation					
1. Monitoring trip (30,000 B x 3 + 3 trips)	90,000	90,000	180,000		5%

Program monitoring and evaluation sub total	***90,000***	***90,000***	***180,000***		**5%**
E) Management Meeting					
1. Leading group meeting (5,000 B x 1+1 time)	5,000	5,000	10,000		0%
2. Executive Board meeting (1,000 B x 6+6 times)	6,000	6,000	12,000		0%
3. Staffs meeting (500 B x 24+24 times)	12,000	12,000	24,000		1%
Management Meeting sub total	***23,000***	***23,000***	***46,000***		**1%**
Program Management and Evaluation sub total	***1,589,000***	***1,589,000***	***3,178,000***	**8.8%**	***100%***
VII. General Administration					
A. Office running cost					
1. Office running cost (60000 B x 6mths)	**360,000**	**360,000**	**720,000**		**26%**
B. Office supplies					
1. Office furniture	20,000	20,000	40,000		2%
2. Computer maintenance	10,000	10,000	20,000		1%
3. Money Transfer Fees	20,000	20,000	40,000		2%
4. Car warranty and maintenance (New vehicle)	600,000	30,000	630,000		25%
5. Cabinet 3,000 B x 20 sets)	60,000	0	60,000		2%
Office supplies total	**710,000**	**80,000**	**790,000**		**28%**
C. staff stipend					
1. Office staff' stipend (4,000 B x 3 persons x 6 mths)	72,000	72,000	144,000		6%
2. Office manager stipend (7,000 x 1person x 6 mths)	42,000	42,000	84,000		3%
3. Social support	100,000	100,000	200,000		8%
4. Registration (6,000 B x 5 Persons)	30,000	0	30,000		1%
5. Intern stipend (1,500 B x 3 persons x 6month)	27,000	27,000	54,000		2%
staff stipend total	**271,000**	**241,000**	**512,000**		**18%**
D. Other Administration					
1. Auditor fee	50,000		50,000		2%
2. Air Ticket Fees (20,000 B x 2 persons x 1+1 time)	40,000	40,000	80,000		3%
3. Domestic traveling cost (5000 B x 2 persons x 2 times)	20,000	20,000	40,000		2%
4. Immigration (2000 B x 8 time x 2 persons)	32,000	0	32,000		1%
5. Attending local coordination meeting	50,000	50,000	100,000		4%

6. Computer (Desktop) 2 Sets (30,000 B x 2 Sets)	60,000	0	60,000		2%
7. Meeting hall Renovation	70,000	0	70,000		3%
8. Dealing with border committee (3000B x 6+6 mths)	18,000	18,000	36,000		1%
9. Distance transportation (6,000 B x 6 + 6 mths)	36,000	36,000	72,000		3%
10. Emergency Health care	100,000	100,000	200,000		8%
11. Security cost (3000 B x 6 + 6 mths)	18,000	18,000	36,000		1%
Other administration cost total	**494,000**	**282,000**	**776,000**		**28%**
Total Administration	***1,835,000***	***963,000***	**2,798,000**	**7.8%**	***100%***
Grand total for all program in year 2011	**18,849,400**	**17,172,000**	**36,021,400**	**100%**	**100%**