နယ်လှည့်ကျောပိုးအိတ်ကျန်းမာရေးလုပ်သားအဖွဲ့
Back Pack Health Worker Team
P.O Box 57, Mae Sot, Tak 63110, Thailand
ph/fax:055545421, email:bphwt@loxinfo.co.th

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

2012 Proposal
Back Pack Health Worker Team

2012 Proposal

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: : 	**190,000** people living within the Mon, Karenni, Kayah, Kayan, Karen, Shan, Lahu, Kachin and Arakan areas
Project Duration:	January to December 2012
Budget requested:	**41,611,500** Thai Baht **(1,387,050 USD)**
Organization:	Back Pack Health Worker Team (BPHWT) P.O Box 57, Mae Sot, Tak, 63110 ,Thailand
Phone/Fax:	+66 5554 5421
Email:	bphwt@loxinfo.co.th

Contact Persons:	Dr. Cynthia Maung	Mahn Mahn
	Chairperson	Secretary
	+66 89961 5054	+66 87943 8750

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I. Overview

(i) Background on the Conflict and Internal Displacement in Burma

Burma is a very ethnically diverse country with dozens of indigenous ethnic groups. After independence in 1948, Karen ethnic groups began to take up arms in the country's eastern border regions in pursuit of increased autonomy. In addition to long-running instability in this area, as well as other ethnic-dominant regions, a military coup in 1962 led by General Ne Win marked the start of almost five decades of military rule. The subsequent military regimes holding power in Burma have been widely considered to be among the world's most oppressive governments, due to the denial of democratic freedoms; the widespread and systematic perpetration of human rights abuses against its own people; and the persecution of its ethnic minority groups. Despite democratic elections being held in 1990, the military generals refused to acknowledge the victory of opposition party, the National League of Democracy (NLD), and imprisoned their leader, Daw Aung San Suu Kyi.

Although some of the armed ethnic groups signed ceasefire agreements with the ruling military regime after 1989, armed conflict continues in many areas of eastern and south eastern Burma. In areas where control is contested between warring factions, the regime continues to employ the controversial "Four Cuts" strategy. By seeking to destroy the four crucial links between armed opposition groups and civilians (food; financial support; potential recruits; and information sources), this military strategy results in the direct targeting of civilian areas, and therefore violates 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

Displaced Mother and Children

1996 to 2010. There are currently more than 450,000 internally displaced people across southeastern Burma[1].

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. Although the country is now theoretically ruled by a 'civilian' government, its leaders have merely denounced their military titles, and the new Constitution continues to restrict the voices of opposition groups. Immediately after the elections, conflict between the Burma Army (or *Tatmadaw*) and armed ethnic groups escalated close to the Thai-Burma border, in response to pressure from the regime to bring ceasefire groups into a centrally-controlled Border Guard Force. This increase in violence resulted in the displacement of approximately 25,000 civilians on both sides of the Thai-Burma border, many of whom have still been unable to return to their homes. Despite initiating some semblance of dialogue with some armed factions in 2011, there is a long, uncertain path ahead before meaningful, sustainable peace might be achieved.

Meanwhile, Tatmadaw forces continue to routinely commit widespread human rights violations against ethnic civilians with alarming frequency. These widely documented 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 the situation of human rights in Myanmar, Tomás Ojea Quintana, to call for a United Nations-mandated Commission of Inquiry into crimes against humanity, and war crimes in Burma.

(ii) The General Health Situation in Burma

Public health is another casualty of decades of military rule and ethnic oppression. Burma's current rulers have not deviated from the negligent socio-economic policies of the past and continue to chronically neglect basic, essential social services. 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

[1] Thailand-Burma Border Consortium, 2011, *Displacement and Poverty in South East Burma/ Myanmar.*
[2] Sean Turnell 2009 Burma Isn't Broke, Wall Street Journal, August 6th.
[3] UNDP 2009 Human Development Report

spends 1.8% of total government expenditures on health, leaving Burma in the 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).

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 fatality rate of any country in Southeast Asia.

(iii) The Health of Internally Displaced Persons:

While the health indicators of Burma's population rank amongst the poorest globally, the health of Internally Displaced Persons (IDPs) within Burma is even more serious cause for concern. Health indicators for the rural ethnic populations in eastern and south eastern areas are demonstrably worse than Burma's national rates. IDPs face harsh living conditions in the jungle; their means of survival are a constant challenge. In addition to dealing with the burden of protracted conflict and the high frequency with which they are forcibly displaced, access to state healthcare systems is either extremely limited or non-existent. This situation has resulted in mortality rates which are comparable with some of the world's most volatile countries at war, as shown in the following table:

"Mortality Rates"				
	Burma National	**Eastern Burma**	**Sudan**	**D. R. Congo**
Maternal mortality (Per 100,000 live births)	240	721	750	670
Under 5 mortality (Per 1,000 live births)	71	138	108	199
Infant mortality (Per 1,000 live births)	54	73	69	126

[4] UNDP 2009 Human Development Report
[5] United Nations Children's Fund, Level & Trends in Child Mortality, 2010
[6] Ibid

Eastern Burma's demographics are characterized by high birth rates, high death rates and the significant absence of men under the age of 45. These patterns are more comparable to recent war zones, such as Sierra Leone, than to Burma's national demographics.

In 2010, BPHWT published a report entitled ***Diagnosis: Critical***[7]**,** which demonstrates that a chronic health emergency exists in eastern Burma. The survey-based report, covering 21 townships and 6,372 households in both ceasefire and non-ceasefire areas, brings to light a legacy of longstanding, official disinvestment in health, coupled with protracted civil war and the abuse of civilians. The data showed that among the rural eastern population, child mortality rates are twice as high as the national average. Furthermore, 60% of deaths in children under the age of 5 are caused by preventable and treatable diseases (for example, acute respiratory infection, malaria, and diarrhea). Infectious diseases are the primary cause of death for both children and adults, with malaria accounting for almost half of all deaths. Moderate to severe malnutrition is also prevalent within IDP populations, at levels consistent with those found in Africa. 41.2% of children under five are acutely malnourished. 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.

Providing Antenatal care to a IDP woman

The estimated Maternal Mortality Rate within the IDP population ranks amongst the highest in the world. One in twelve women in Eastern Burma is at risk of death as a result of pregnancy or childbirth, a rate three times higher than the national average[8]. Since most causes of maternal death are preventable within a functioning health system, this is strongly indicative of the lack of reproductive health-related care and services. In a survey conducted in 2010 across the eight States and Divisions in which the BPHWT medics operate, 88% of births were shown to take place at home instead of in a hospital or clinic, usually only with

[7] Technical support for the data collection and analysis was provided by the Global Health Access Program and the Centre for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health.

[8] *Diagnosis: Critical – Health and Human Rights in Eastern Burma*, Consortium of border based health organizations, October 2010 http://www.backpackteam.org/wp-content/uploads/reports/Diagnosis%20critical%20-%20Eng%20website%20version.pdf, page 10

the assistance of a Traditional Birth Assistant (TBA)[9]. In unstable environments, it is not uncommon for internally-displaced women to deliver their baby in the jungles located deep inside Burma, while hiding from the Burmese army patrols. Overall, only 4 % of IDP women had access to emergency obstetric care, and many also lack awareness of the dangers of pregnancy complications and how to avoid them. For example, the survey showed that only 41.1% received any iron supplements during their previous pregnancy.

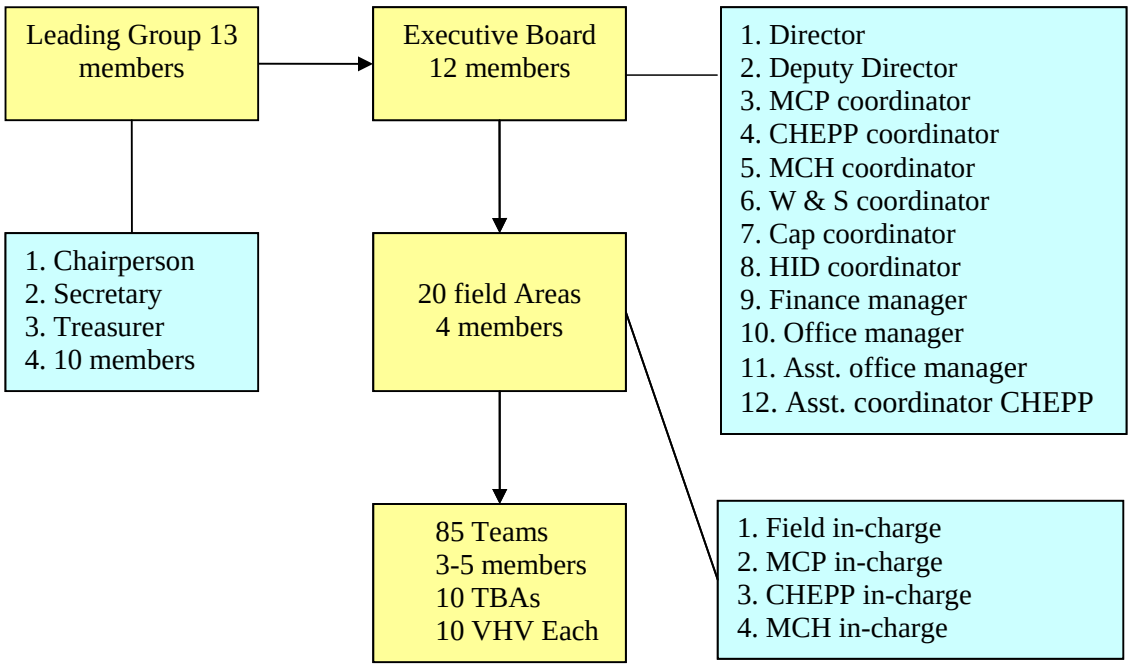
In this harsh, unstable environment, Non-Government Organizations (NGOs) and Community-Based Organizations (CBOs) provide vital recourses and knowledge to preserve lives. In should be noted that less than 4% of foreign aid to Burma reaches these conflict-affected areas, most of which is channelled discreetly across the border humanitarian organization located in Thailand[10]. In partnership with international donors, international humanitarian agencies, and ethnic health organizations, these CBOs and NGOs deliver healthcare to internally displaced persons through both preventive and curative approaches. Without assistance from organizations such as BPHWT, many IDPs would have no access to healthcare.

II. The Back Pack Health Worker Team: The BPHWT was established in 1998 by Karenni, Mon and Karen health workers to provide healthcare to Internally Displaced Persons living along the eastern border of Burma, affected by over 60 years of civil war. In 2011, the BPHWT has so far provided healthcare in 20 field areas with **84** teams, to a target population of over **180,000** people. There are currently about **1,300** healthcare workers connected to BPHWT living and working in Burma, comprised of **247** medics, **617** traditional birth attendants (TBAs) and **428** village health volunteers (VHVs). The BPHWT plans to increase the number of teams to **95** in 2012. Since the Burmese government does not provide any health services in the ethnic community regions, and INGOs are severely limited in accessing these areas due to government restriction, the BPHWT needs to increase the number of teams to reach a larger target population in these marginalized communities.

[9] Impact Assessment Survey, BPWHT, June 2011, page 16

[10] *Protracted Displacement and Chronic Poverty in Eastern Burma/ Myanmar*, Thailand-Burma Border Consortium, 2010, page 12.

(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 regions 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 financial policies and procedures guiding the Leading Committee, Executive Board, Coordinators 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) Service System: Since 1998, the Back Pack Health Worker Team has been working towards developing an accessible, community based, primary healthcare service system within the BPHWT Field Areas, based on the health access indicators.

Health Access Indicators for a Community Based Primary Healthcare System

Population	Health Service Type	Health Workers	RATIO (workers/pop)	IDEAL Number
2000	BPHWT (Community based primary healthcare unit)	BPHWT Health Worker	1/400	5
		Traditional Birth Attendant	1/200	10
		Village Health Volunteer	1/500	10
Total Health Workers Per Team				**25**

(iv) Gender Policy and Analysis: In 2011, fifty-five percent of the BPHWT staff was composed of women, excluding Traditional Birth Attendants (TBAs). 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 meets or exceeds all gender equality targets for organizational tiers, except for the target set for Office Staff.

Gender Analysis of the People Working within the BPHWT as of 2010

Category	Total # of Workers	Total # of females	Females Actual %	Females Target at Least %
Leading Group/Executive Board	15	7	47%	**30%**
Office Staff	11	3	**27%**	**30%**
Field Management Workers	57	28	49%	**30%**
Field Health Workers	233	102	44%	**30%**
Traditional Birth Attendants	672	582	87%	**Target not set**
Village Health Volunteers	495	306	62%	**30%**
Total Organization	**1483**	**1028**	69%	**Target not set**
Total Organization without TBAs			**55%**	**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, Maternal and Child Healthcare, and Water and Sanitation Programs in the target areas. 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 2010, the BPHWT treated **97,473** cases, and by mid-year 2011, they had treated **36,390** 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 (which are delivered by international consultants), and 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' skills 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 nearest 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 healthcare 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-

Providing a gravity flow to communities

program provides the community with the health knowledge to be able to take independent measures to improve hygiene conditions, develop water and sanitation systems, improve nutrition, prevent and control the communicable disease of Lymphatic Filariasis, and manage basic healthcare. The program also distributes Vitamin A and de-worming medication, builds safe water supplies and constructs latrines.

CHEPP objectives:

- Reduce the incidences 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 the 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 the ages of 1 to 12 years
- Provide school health education, village health workshops and health campaigns
- Organize Village Health Volunteer training and workshops
- Provide Water and Sanitation systems
- Provide Mass Drugs Administration among the community and educate community members about Lymphatic Filariasis

(iii) Maternal and Child Healthcare Program (MCHP): In Maternal and Child Healthcare Program, capacity building is delivered through the 48 hour TBA Training Course, 20 day level 2 TBA training and 3 day TBA Field Workshops every six months in field areas. TBA follow-up workshops are held throughout the field every six months as well. The BPHWT has a criteria to recruit new TBAs; the TBAs who will work in this program need to have had the experience of delivering at least five babies and must have attended at least two TBA workshops. Additionally, they have to be recommended by the

Providing Delivery Records

communities. As a result, the TBAs who are working in the MCH program already have the experience of delivering five babies or more.

Maternal and Child Health (MCH) Supervisors attend the 6-monthly Reproductive Health Workshops. 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 the utilization of, family planning
- Improve the knowledge and skills of TBAs and MCHP supervisors
- Provide delivery records

MCHP activities:

- Distribute Vitamin A and iron tablets 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 workshops
- Document deliveries

(IV) Integrated Capacity Building Program: The Back Pack Health Worker Team (BPHWT) organizes short training courses in order to upgrade health workers' skills and knowledge, which are attended by BP field in-charges, field MCH supervisors, TBA trainers, other BP health workers and invited technical consultants from international NGOs. The BPHWT also organizes community health worker and refresher training courses, in collaboration with local health organizations.

Medical refresher training course in 2011

Capacity building objectives:

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

Capacity Building activities:

- Conduct short training courses on management skills and capacity building for office staff
- Conduct short training courses and training of trainer courses that relate with the 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 skills trainings to women

(V) Health Information and Documentation: The BPHWT collects health information, documents evidence of the health situation and assesses the community needs in eastern Burma. This integrated program also plays a role in monitoring and evaluation of the programs. The BPHWT assesses health needs annually and conducts impact assessment surveys every two 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

Key Health Indicators

Health Indicators	Target Group	Measurement Tool
1. Malaria Morbidity Rate	Entire population	Annual data analysis and Program Impact Assessment Survey every 2 years
2. ARI Morbidity Rate	Entire population	Annual data analysis
3. Dysentery and Diarrhea Morbidity	Entire population	Annual data analysis and Program Impact Assessment Survey every 2 years
4. Child Mortality Rate	Children under 5 years and infants	Program Impact Assessment Survey every 2 years
5. Number of pregnant women receiving Iron	Pregnant women	Annual analysis of iron supplement data
6. Number of TBAs practicing clean	Traditional Birth Attendants	TBA assessment survey every 2 years
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 every 2
	Pregnant women	Annual analysis of Vitamin A data
9. Percentage of people who have and use latrines	Entire population	Program Impact Assessment Survey every 2 years
10. Number of community participation in workshops	Entire Population	Annual Analysis of participants in workshops
11. Number of student participation in school	Students	Annual analysis of number of students data
12. Percentage of mothers who give ORS	Women with children who have diarrhea	Program Impact Assessment Survey every 2 years
13. Maternal Mortality Ratio	Women during pregnancy and up to 42 days post-	Annual analysis of TBA data and Program Impact Assessment Survey every 2 years

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 organizes 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 (MTC), Burma Medical Association (BMA), local ethnic health departments, and the National Health and Education Committee (NHEC). The technical assistance of BPHWT is supported by the Global Health Access Program (GHAP), in terms of designing public health, data instrument, preparation and monitoring of health indicators.

BPHWT Semi-Annual meeting in Mae Sot

The field in-charges from twenty field areas organize field meetings every six months, which include 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 Operational Areas

VI. Logical Framework of BPHWT Programs in 2012: The BPHWT programs and descriptions of 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 healthcare**						
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**2012 EXPECTED Results**	**2012 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 - Provide ITNs - Provide Malaria rapid tests - Provide ACT to patients with malaria	- No. of BP target teams, population and total case-load (f/m), under/over 5) - No. of villages covered - No. of ITNs provided - No. of HHs and people receiving ITNs - Percentage of Households sleeping under ITNs (baseline – 71% in 2010) - No. of malaria rapid test provided - No. of ACT provided - Percentage/Number of children (CASES) under 5 treated by BP health workers who receive appropriate anti-malarial treatment (include presumptive treatment and no. of cases treated by BPHWT)(baseline-93%	- Procurement delivery documents; Log books - Analysis of data collected - Impact Assessment Survey 2013 - field in-charge reports - Malaria data form - field in-charge reports	- 95 BP teams - 190,000 Targeted population - 95,000 cases being treated (no. of families & HH, no. of f/m and under/over 5, no. of villages covered) - 7,000 ITNs will benefit 7,000 HHs or 35,000 people - 80% of HHs sleeping under ITNs - 14,250 rapid test will be provided - 7,000 malaria cases will be treated with ACT - 95% of children under 5 treated who receive appropriate anti-malarial treatment.			- Insufficient funding - Security concerns - Data lost, stolen or incomplete

		in 2010) - Number and percentage of (CASES) women and men diagnosed with PF malaria by BPHWT who are treated with ACT in BPHWT target population(baseline – F-3103,M - 3606 Total: 6709 individuals in 2010) - Malaria mortality rates per 1,000 population (baseline-3.5 malaria case deaths per 1000 population) - Mortality rates among children under 5 years old per 1,000 live births in target population (baseline-138) - Percentage of under 5 children with malnutrition (according to accepted guidelines for MUAC cutoffs) (Baseline – 16.5%)	- field in-charge reports - 2013 Impact Assessment Survey - 2013 Impact Assessment Survey - 2013 Impact Assessment Survey	- Female - 3500 Male - 4000 Total: 7500 individuals - 2.5 malaria case deaths per 1000 population - 130 children under 5 years old per 1,000 live births in target population - 14% of under 5 children with malnutrition			
	- Provide treatment handbooks	- No. of treatment hand-books provided	- Annual report	- 500 treatment handbooks will be provided			
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	- No. of Health Workers participated	- Field in-charge reports - Workshop reports - Log book review & analysis	- 180 attend Field Workshops - 100 health workers attend 6 month			- High travel risk due to security issues

	training	-% of Improving diagnosis & treatment - Percentage of health workers who achieved a defined passing score, including knowledge on identifying standardized health protocols, based on common /harmonized guidelines (Baseline-75% in 2010)	- Mid - year & Annual Reports - Health Worker Assessment - 2013	workshops(f/m) - % of Improving diagnosis & treatment - 95% of health workers who achieved a defined passing score, including knowledge on identifying standardized health protocols, based on common /harmonized guidelines			
4. Improve patient referral systems	- Refer patients to the nearest hospitals or clinics.	- No. of referrals - list of referral sites - No. of f/m referral patients	- Mid - year & Annual Reports -Patient's referral forms	- **85** 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 incidences of malnutrition and worm infestation	- Distribute Vitamin A to children between the ages of 6 months to 12 years -Distribute de-worming medicine to children between 1 to 12 years	- No. of children receiving Vitamin A - No. of children receiving de-worming medicine	- Health Worker Data forms and field in-charge reports	- 40,000 children will receive Vitamin A - 35,000 children will receive de-worming medicine			
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 participants in event (f/m) (World AIDS day)	- Field reports - Mid - year & Annual Reports - VH workshop reports	- 95 school sessions attended by 9,500 students - 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) - 95 World AIDS events for 14,250 people			- Time limitations of community members
3. Improve community level knowledge and	- Organize village health worker trainings and	- No training sessions and VHW attended (f/m)	- Field reports - Mid - year & annual reports	- 20 VHW trainings for 400 new VHWs (f/m)			- Participant Turnover attending the workshop

participation in health	workshops - Provide VHW kits - Provide VHW hand-books	- No. workshop sessions and VHWs participated - No. of VHW kits provided - No. of VHW handbooks provided	- VHW training and workshop reports	- 155 sessions of VHW workshop for 3,100 VHWs (f/m) - 400 VHW kits will be provided - 1000 VHW handbooks will be provided			
4. Improve water and sanitation systems in the community to reduce water-borne diseases	- Provide water and sanitation systems	- No. & type of latrines built and No. of HHs and people benefiting from latrines - No. & type of water systems installed -No. of HHs and people benefiting from water systems (f/m) - % of people using latrines (always and sometimes) (Baseline - 98%)	- Field reports - Mid - year & Annual Reports - Impact Assessment Survey 2013	- 800 school latrines will benefit 16,000 students - 5,000 community latrines or will be benefited 50,000 pop; - 20 gravity flow water systems 1200 house-holds (6000 Pop) - 60 shallow well systems 600 house-holds (3000 pop) - 99% of people using latrines			- Insufficient funding - Hostile military activity prevents transportation and installation
5. Prevent and control the communicable disease of Lymphatic Filariasis	- Provide Mass Drugs Administration to the community - Provide awareness workshops	- No. of people receiving drug (f/m & under/over 5) - No. of participants	- field reports - mid-term reports	- 13,000 people will receive Albandazone and DEC. (f/m and under/over 5) - 5 sessions of awareness workshops to 1,500 (f/m) people			- Community complaints of side-effects - Security concerns
Mother and Child Healthcare Program							
1. Increase maternal and child	- Distribute Vitamin A and Albandazole	- No. of pregnant women receiving	- field reports	- 4,000 pregnant women will receive			- Security issues can affect data level

healthcare	- Provide iron prenatally and postnatally to pregnant women - Referral of serious obstetric cases - provide ANC to pregnant women - Provide OG instruments	Vitamin A and Albandazole - No. of pregnant women receiving iron - No. of serious obstetric cases - No. and % of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010) - % of children 0-5 months who are fed exclusively with breast milk in target population (baseline -23%) - No. and % of trained Traditional Birth Attendants who can identify at least 3 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines(Baseline-45% -2010) - No. of OG instruments provided	- TBA's form - Impact Assessment Survey 2013 - TBA assessment 2013 - TBA assessment 2013 - Distribute list	Vitamin A and Albandozole - 4,000 pregnant women will receive iron - 25 obstetric cases referrals - 50% of pregnant women in target population with at least four ANC - 30% of children 0-5 months who are fed exclusively with breast milk in target population - 50% of TBAs who can identify at least 3 signs of pregnancy complications - 60 sets of OG instruments will be provided			returned
2. Raise awareness among villagers on family planning and provide them with family planning supplies	- Provide family planning supplies - Provide family planning education	- No. of clients receiving the family planning supplies (f/m) - No. of people using family planning methods (Baseline-22.9%)	- Mid-year & Annual Reports - Impact Assessment Survey 2013	- 4,000 people using family planning methods (8% of 44,941 reproductive age) - 35% people using family planning methods			- Traditional cultural barriers
3. Improve knowledge & skills of TBAs & MCH Supervisors	- Conduct TBA training - Conduct level 2	- No. of new TBAs - No. of new TBAs who	- Workshop reports - Field reports - Field photos - Mid - year & annual reports	- 5 sessions of TBA training attended by 50 new TBAs (f/m) - 20 sessions of level 2			- Security issues affect travel - Traditional cultural barriers

	TBA training and provide handbooks for TBAs - Conduct TBA field and reproductive health workshops - Provide safe birthing kits	complete the training - No. of TBA Follow-up Workshops held & no. of TBAs attending (f/m) - % of TBAs 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 (Baseline – TBA -67%, health worker – 27%) - No. of TBA kits provided - No. of Maternity Kits provided -Appropriate sterile instruments (new razor blades, sterile scissors, etc) = 326 (79%)-2010 - Povidine/ Iodine or other antiseptics = 354 (85%)-2010 - -Provide at least 3 health information topics to women they deliver = 353 (85%) -2010	- TBA forms - Mid-term and annual reports - TBA assessment	TBA training for 400 people (f/m) 500 level 2 TBA handbooks will be provided - 70 Follow-up TBA Workshops for 700 (f/m) TBAs - % of TBAs who receive a score of at least 85% on the post-test - 4,000 babies delivered by trained TBAs and health workers (60% by TBAs and 30% by health workers of 4,000 pregnant women) - 1,850 TBA kits - 5,800 maternity kits - Appropriate sterile instruments (new razor blades, sterile scissors, etc) 87% Povidine/ Iodine or other antiseptics 92% -Provide at least 3 health information topics to women they delivered 92%			
4. Provide delivery records	- Document deliveries	- No. of newborns received delivery records	- Delivery records issued copies	- 2,100 delivery records			- Security concerns - Traditional cultural barriers
Capacity Building							

1. Improve health worker and staff knowledge and skills	- CHW TOT training - MCH TOT training - CHW training - VHW TOT training - MCH refresher training course - Medical Refresher training course - Trauma care workshop - Attendant international conferences and trainings - Local and international health institutions	- No. of CHWs who attend the TOT training (f/m) - No. of MCH supervisors who attend the TOT training (f/m) - No. of trainees who complete CHW training (f/m) - No. of VHW trainers who attend VHW TOT - No. of MCH workers who complete MCH refresher training course - No. of trainees who complete medical refresher course training (f/m) - No. of people who participate in Trauma care workshop - No. of times people participate in conferences and trainings - No. of people who attend local and international health institutions	- Attendant list - Attendant list - Attendant list - Attendant list - Attendant list -Training report - Attendant list	- 1 CHW TOT for 20 CHW (f/m) - 1 MCH TOT for 20 MCH supervisors (f/m) - 4 CHW trainings for 120 CHW (f/m) - 1 VHW TOT for 30 VHW trainers (f/m) - 1 MCH refresher training course for 30 MCH supervisors (f/m) - 1 medical refresher training course for 30 medics (f/m) - 2 Trauma care workshop for 40 people - 2 international and 6 local conferences or trainings - 10 staff will attend local and international health institutions			- Security concerns affected in training location - Resettlement - traveling document
2. Promote gender equality in leading positions	- Provide management skills 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	- Produce HID materials - Provide digital cameras and video cameras	- No. of calendars and no. of article reports provided - No. of digital cameras and no. of video cameras provided	- Field in-charge report - HID staff report	- 1,000 calendars, and 5 article reports provided in a year - 20 digital cameras and 2 video cameras will be provided			
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 field meetings and workshops	- No. of field meetings or workshops provided - No. of participants	- Field meetings and workshop reports	- Twice a year for 20 field areas - 80 people participate in field workshops and meetings			
4. Raise awareness of the community health problem	- Produce health information, education and communication materials	- No. of posters and pamphlets provided	- IEC distributing list	- No. Posters will be provided			
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 seminars - No. of abstract papers produced	- Annual year report	- At least once a year - 4 abstract papers related to health issues produced			
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	- Conduct monitoring trips - Conduct six months meeting - Conduct Leading Group meetings - Conduct monthly Executive Board meetings - Conduct weekly staff meetings	- No. of monitoring trips and no. of staff - No. of health workers who attend the six months meeting - No. of Leading Group meetings - No. of Executive Board meetings - No. of staff meetings	- mid-year & annual reports	- 6 monitoring trips in a year - 100 health workers attend the six months meeting - 4 Leading Group meetings per year - 12 Executive Board meetings per year - 48 staff meetings per year			

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

Program Activity Timelines

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, population information	✓						✓					
4. Provide ITNs			✓	✓					✓	✓		
5. Provide ACT to patients with malaria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Provide malaria rapid tests			✓	✓					✓	✓		
7. Purchase emergency medical supplies	**As necessary**											
8. Field Meetings	✓						✓					
9. Village Health Workshops			✓	✓					✓	✓		
10. 6 monthly meetings/workshops		✓						✓				
11. Field workshops			✓						✓			
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. Provide mass drugs administration			✓	✓					✓	✓		
11. Conduct LF awareness workshops		✓						✓				
Maternal and Child Healthcare Program												
1. TBA training			✓	✓								
2. Level 2 TBA training									✓	✓		
3. TBA meetings				✓	✓							
4. TBA workshops			✓	✓					✓	✓		
5. Provide TBA Kits and Maternity Kits			✓	✓					✓	✓		
6. Distribute Vit-A and Albandazole to pregnant women			✓	✓					✓	✓		
7. Distribute Iron prenatally and postnatally			✓	✓	✓	✓			✓	✓	✓	✓
8. Referral of serious obstetric cases	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Provide Family Planning supplies			✓	✓	✓	✓			✓	✓	✓	✓
10. Provide Family Planning education				✓	✓	✓	✓				✓	✓
11. Hold Reproductive Health Workshops		✓						✓				
12. Document and issue delivery records	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Capacity Building												
1. Organize community health worker training				✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Organize CHW TOT		✓										
3. Organize MCH TOT		✓										
4. Organize VHW TOT			✓									
5. Organize MCH Refresher Training courses				✓	✓	✓						

6. Organize Refresher Course for senior medics									√	√	√	√
7. Organize First Aid training			√	√					√	√		
8. Organize Trauma Care workshop		√										
9. Attend local and international conferences and trainings					√	√			√	√		
Health Information and Documentation												
1. Conduct community needs assessment	√	√				√	√					
2. Provide HID materials	√	√				√	√					
3. Analyze data collected by health workers	√	√				√	√					
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 monthly meeting	√						√					
3. Organize Leading Group meeting	√						√					
4. Organize Executive Board meeting	√	√	√	√	√	√	√	√	√	√	√	√
5. Organize weekly staff meeting	√	√	√	√	√	√	√	√	√	√	√	√

VIII. Management, Monitoring and Evaluation

(i) Organizational 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 organizations to develop and improve programs. Some examples of the technical assistance BPHWT has received in 2007 include: reviewing field log books; reviewing and rationalizing 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. BPHWT utilizes an Internal Program Monitoring Team (IPMT) in order to evaluate the improvement of the activities and is particularly focused on Quality Control (Drug and Health workers' skills), Logistic Management, Office/Program Administration and the improvement of women participation.

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 organization. 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 organizations in February 2012.

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	Quarterly	- 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 are conducted by external consultants or organizations. The table below summarizes the current Monitoring and Evaluation framework.

Topic	Method	Participants	Frequency	Evidence & Reporting
Quality of field health workers' 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	Biennially	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 Triennially	Audited Financial Report included in the Annual Report Outcome of elections included in corresponding Annual Report

IX. Budgeting (January to December 2012

Items	Jan-Jun 2012	Jul-Dec 2012	Total	% total budget	% by program
I. Medical Care Program (MCP)					
A) MCP program operation cost					
1. Program coordinator operation cost (8,000 B x 6 mths x 1 person)	48,000	48,000	96,000		1%
2. Program staff operation cost (4,500 B x 6 mths x 1 person)	27,000	27,000	54,000		0%
MCP program operation cost sub total	**75,000**	**75,000**	**150,000**		**1%**
B) MCP Activities and supplies					
1. General Medicine & Medical supplies (30,000B x 95 BPs)	2,850,000	2,850,000	5,700,000		37%
2. Malaria Medicine & supplies (20,000B x 95 BPs)	1,900,000	1,900,000	3,800,000		24%
3. Malaria rapid test (40 B x 200 x 95BPs)	760,000	760,000	1,520,000		10%
4. Mosquito net - ITN(150 B x 3,500 + 3,500)	525,000	525,000	1,050,000		7%
5. Medicine transportation (3,000 B x 95 BPs)	285,000	285,000	570,000		4%
6. MCP worker's operation cost (1,200 B x 6 mths x 85 persons)	612,000	612,000	1,224,000		8%
7. Field-coordinator operation cost (1500 B x 6 mths x 20 persons)	180,000	180,000	360,000		2%
8. Emergency medical supplies	400,000	400,000	800,000		5%
9. Treatment Hand Book (150 B x 500 Books)	75,000	0	75,000		0%
10. Report form	10,000	10,000	20,000		0%
11. Log book	15,000	15,000	30,000		0%
12. Malaria Medicine & supplies for Health center (15,000 Bx 6 centers)	90,000	90,000	180,000		1%
13. Malaria rapid test for Health center (40B x 150 x 6 centers)	36,000	36,000	72,000		0%
MCP Activities and supplies cost sub total	**7,738,000**	**7,663,000**	**15,401,000**		**99%**
MCP Sub Total	**7,813,000**	**7,738,000**	**15,551,000**	**37.4%**	**100%**
II. Community Health Education and Prevention Program (CHEPP)					
A) Program Operation Cost					
1. Program coordinator operation cost (8,000 B x 6 mthsx 2 persons)	96,000	96,000	192,000		2%
2. Program staff operation cost (4,500 B x 6 mths x 1 person)	27,000	27,000	54,000		1%
3. CHEPP 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 (1,500 B x 6 moths x 20 fields)	180,000	180,000	360,000		5%
Program operation cost sub total	***915,000***	***915,000***	***1,830,000***		**23%**

B) 1.Village Health Worker Training/Workshop					
1. Village Health Worker Training (25,000B x 10+10 training)	250,000	250000	500,000		6%
2. Village Health Worker Workshop (3,000B x 20 workshop)		60,000	60,000		1%
VHV Training/workshop sub total	***250,000***	***310,000***	***560,000***		**7%**
C) School Health Promotion					
1.Personal hygiene (20 B x 100 students) x 95 BPs		190,000	190,000		2%
2. Latrine (500B x 10 x 80 sessions)		400,000	400,000		5%
3. Health Camping event (2,000 B x 95 BPs)		190,000	190,000		2%
School Health Promotion sub total	**0**	**780,000**	***780,000***		**10%**
D) Village Health Workshop (3,000 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		9%
2. Shallow well water system (5,000 B x (30 +30) sessions	150,000	150,000	300,000		4%
3. Community Latrine (500B x 2500 + 2500 latrines)	1,250,000	1,250,000	2,500,000		31%
Water & Sanitation sub total	***1,750,000***	***1,750,000***	***3,500,000***		**44%**
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. Awareness workshop 2,000 B x 5sessions)	10,000	-	10,000		0%
4. Personal Operation cost (1,200 B x 6 mths x 5 staffs)	36,000	36,000	72,000		1%
Communicable disease Control (Filiariasis Pilot Program)sub total	**218,400**	**128,000**	**346,400**		**4%**
H) IEC materials					
1.VHW curriculum / Hand Book (100B x 1000 Book)	100,000		100,000		1%

IEC materials sub total	**100,000**	**0**	**100,000**		**1%**
CHEPP Sub total	***3,660,900***	***4,310,500***	***7,971,400***	**19.2%**	***100%***
III. Maternal and Child Health Program (MCHP)					
A) Program Operation Cost					
1. Program coordinator operation cost (8,000 Bx 6 mths x 2 persons)	96,000	96,000	192,000		3%
2. Program staff operation cost (4,500 B x 6 mths x 1 person)	27,000	27,000	54,000		1%
3. MCH workers operation cost (1,200 B x 6 mths x 85 persons)	612,000	612,000	1,224,000		20%
4. Field coordinator operation cost (1,500B x 6 mths x 19 person)	171,000	171,000	342,000		5%
5. STTBA Curriculum (hand book) 500 x 70 B	35,000	0	35,000		1%
MCHP program operation cost sub total	***941,000***	***906,000***	**1,847,000**		30%
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. Stationery and documentation (1,000B x 5 sessions)	5,000	0	5,000		0%
5.TBA kit and Maternity Kit transportation(1,500B 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+35 sessions)	126,000	63,000	189,000		3%
2. TBA Kit (400 B x 10 TBAs x 70+35sessions)	280,000	140,000	420,000		7%
3. Maternity Kit (150 B x 4 mothers x 10 TBAs x 70+35 sessions)	420,000	210,000	630,000		10%

4. TBA and Maternity kit transportation (1500 B x 70+35sessions)	105,000	52,500	157,500		3%
5. Stationery (500B x 70 +35sessions)	35,000	17,500	52,500		1%
6. TBA compensation (500B x 10 TBAs x 70 +35sessions)	350,000	175,000	525,000		8%
MCHP Follow-up workshop sub total	***1,316,000***	***658,000***	***1,974,000***		**32%**
C) Level 2 TBA Training					
1. Food (50 B x20 persons x 20 days x 20sessions)	*0*	*400,000*	*400,000*		6%
2. TBA Kit (400 B x 20 TBAs x 20sessions)	*0*	*160,000*	*160,000*		3%
3. Stationery and documentation (5,000 B x 20 sessions)	*0*	*100,000*	*100,000*		2%
4. TBA compensation (500B x 20 TBAs x 20sessions)	*0*	*200,000*	*200,000*		3%
5. Local transportation (5,000 B x 20 session)	*0*	*100,000*	*100,000*		2%
Level 2 TBA Training	***0***	***960,000***	***960,000***		15%
D) MCH Worker Instrument (5000B x 60)	***0***	***300,000***	***300,000***		5%
F) Delivery record	***30,000***	***0***	***30,000***		0%
G)Family Planning					0%
1.Family Planning Supplies	*100,000*	*100,000*	*200,000*		**3%**
2.Family Planning Education (1,000Bx95bp x 1 term)	*95,000*	*95,000*	*190,000*		**3%**
Family Planning sub total	***195,000***	***195,000***	***390,000***		**6%**
H) Integrated TBA's Activity					**0%**
a.TBA Training (Chin,Kareni and Special regions)					**0%**
1. Food (50 B x 12 persons x 3 days x 10 sessions)	18,000	18,000	36,000		**1%**
2. TBA Kit (400B x 10 TBAs x 10 sessions)	40,000	40,000	80,000		1%
3. Maternity Kit (150 B x 4 mothers x 10 TBAs x 10 sessions)	60,000	60,000	120,000		2%
4. Stationery and documentation (1,000B x 10 sessions)	10,000	10,000	20,000		0%
5.TBA kit and Maternity Kit transportation(1,500B x 10 sessions)	15,000	15,000	30,000		0%
6. TBA Compensation (500B x 10 TBAs x 10 sessions)	50,000	50,000	100,000		2%
TBA training sub total	***193,000***	***193,000***	**386,000**		6%
b.TBA Workshop (Chin, Kareni and Special regions)					0%
1. Food (50 B x 12 persons x 3 days x 6	10,800	10,800	21,600		0%

sessions)					
2. TBA Kit (400B x 10 TBAs x 6 sessions)	24,000	24,000	48,000		1%
3. Maternity Kit (150 B x 4 mothers x 10 TBAs x 6 sessions)	36,000	36,000	72,000		1%
4. Stationery and documentation (1,000B x 6 sessions)	6,000	6,000	12,000		0%
5.TBA kit and Maternity Kit transportation (1,500B x 6 sessions)	9,000	9,000	18,000		0%
6. TBA Compensation (500B x 10 TBAs x 6 sessions)	30,000	30,000	60,000		1%
TBA Integrated sub total	***115,800***	***115,800***	***231,600***		**4%**
MCHP Follow-up workshop sub total					
MCHP Sub Total	***2,899,300***	***3,327,800***	***6,227,100***	**15.0%**	***86%***
IV. Capacity Building Program (CBP)					
A. Capacity Building					
1. CHW training (350,000 B x 2+2 trainings)	700,000	700,000	1,400,000		30%
2. Medical Refresher Training -30 medics (350,000 x 1 + 1 Terms)	350,000	350,000	700,000		15%
3. International Conference and Training	250,000	250,000	500,000		11%
4. VHW TOT Training 1 course	150,000		150,000		3%
5. Training Monitoring & Evaluation	50,000		50,000		1%
6. TOT For MCH Supervisor	30,000		30,000		1%
7.Trainner stipend (7,000B x 2 person x 12 months)	84,000	84,000	168,000		4%
8.Technical Consultant (35,000B x 1person x 12 months)	210,000	210,000	420,000		9%
9.Organization Development training (50,000B x 1 term)		50,000	50,000		1%
10.Project Management Training (50,000B x 1 term)	50,000		50,000		1%
11. Building Renovation	100,000	100,000	200,000		4%
12.Local and international health institution (50,000B x 5+5 persons x 1 time)	250,000	250,000	500,000		11%
Capacity Building Sub total	**2,224,000**	**1,994,000**	**4,218,000**		89%
B)Trauma Care workshop					
1. Food (100 B x 20 persons x 7days x 2session)	14,000	14,000	28,000		1%
2. Stationary (6,000 B x 2 session)	6,000	6,000	12,000		0%
3. Basic needs supplies (500 B x 20 trainees x 2 session)	10,000	10,000	20,000		0%
4. Transportation (1,000 B x 20 trainees x 2		20,000	40,000		1%

sessions)	20,000				
5. Local transportation (5,000 B x 2 session)	5,000	5,000	10,000		0%
6. Security cost (5,000 B x 2 session)	5,000	5,000	10,000		0%
7.Training materials (100,000B x 2 session)	100,000	100,000	200,000		4%
8.Tranining Instrument (20,000B x 2 term)	20,000	20,000	40,000		1%
Trauma care workshop Sub total	**180,000**	**180,000**	**360,000**		8%
C) Health Program Coordination and Development Seminar					
1. Food (100 B x 70 x 3 days)		21,000	21,000		0%
2. Stationery & Documentation		6,000	6,000		0%
3. Local transport & Security expenditures		10,000	10,000		0%
4. Distance transportation		100,000	100,000		2%
5. Data management and Documentation training		25,000	25,000		1%
Health Program Coordination and Development Seminar Sub total	**0**	**162,000**	**162,000**		**3%**
Capacity Building Program sub total	***2,404,000***	***2,336,000***	***4,740,000***	**11.4%**	***100%***
V. Health Information and Documentation (HID)					
A. Health Information & Documentation					
1. Program coordinator operation cost (8,000 Bx 6 mths x 1person)	48,000	48,000	96,000		16%
2. Still digital camera (6,000 B x 10+10 digitals camera)	60,000	60,000	120,000		19%
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		10%
5. Memory stick and video tape	25,000	25,000	50,000		8%
6. Publication (Calendar)	0	70,000	70,000		11%
7. Publication (T-Shirt 150 x 500)	75,000	75,000	150,000		24%
8. Communication Equipment	50,000	0	50,000		8%
Health Information and Documentation Sub total	**298,000**	**318,000**	**616,000**		**100%**
HID Sub total	***298,000***	***318,000***	***616,000***	**1.5%**	***100%***

VI. Program Management and Evaluation					
A) Program managing cost					
1. Leading members Compensation (8,000 B x 5 persons x 6 mths)	240,000	240,000	480,000		14%
2. Director stipend (8,000 B x 1 person x 6 mths)	48,000	48,000	96,000		3%
3. Deputy director stipend (8,000 B x 1 person x 6 mths)	48,000	48,000	96,000		3%
4. Treasurer stipend (8000 B x 1person x 6 mths)	48,000	48,000	96,000		3%
5. Finance manager stipend (8,000 B x 1 person x 6 mths)	48,000	48,000	96,000		3%
6. Accountant stipend (4,500 B x 1 person x 6 mths)	27,000	27,000	54,000		2%
Program managing cost sub total	***459,000***	***459,000***	***918,000***		**26%**
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		13%
2. Stationery and documentation	35,000	35,000	70,000		2%
3. Local transportation	30,000	30,000	60,000		2%
4. Security costs	20,000	20,000	40,000		1%
5. Distance transportation (4,000 B x 100 persons)	400,000	400,000	800,000		23%
6. Personal effects 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	***764,000***	***764,000***	***1,528,000***		**44%**
C) Field Meeting and Workshop					
a. Field Meeting					
1. Stationery 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		7%
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		3%
Field Meeting sub total	***230,000***	***230,000***	**460,000**		**13%**

b. Field Workshop					
1.Stationery 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		3%
Field workshop sub total	**180,000**	**180,000**	**360,000**		**10%**
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. Staff meetings (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	***1,746,000***	***1,746,000***	***3,492,000***	**8.4%**	***100%***
VII. General Administration					
A. Office running costs					
1. Office running costs (65,000 B x 6mths)	**390,000**	**390,000**	**780,000**		**26%**
B. Office supplies					
1. Office furniture	20,000	20,000	40,000		1%
2. Computer maintenance	10,000	10,000	20,000		1%
3. Money Transfer Fees	20,000	20,000	40,000		1%
4. Car warranty and maintenance	70,000	50,000	120,000		4%
5. Cabinet (3,000 B x 20 sets)	60,000	0	60,000		2%
Office supplies total	**180,000**	**100,000**	**280,000**		**9%**
C. Staff stipend					
1. Office staff' stipend (4,500 B x 5 persons x 6 mths)	135,000	135,000	270,000		9%

2. Office manager stipend (8,000 x 1person x 6 mths)	48,000	48,000	96,000		3%
3. Driver stipend (4,000B x 3persons x 6mths)	72,000	72,000	144,000		5%
4. Social support	100,000	100,000	200,000		7%
5. Registration (6,000 B x 15 Persons)	90,000	0	90,000		3%
6. Intern stipend(1,500 B x 10 persons x 6month)	90,000	90,000	180,000		6%
Staff stipend total	**535,000**	**445,000**	**980,000**		**33%**
D. Other Administration					
1. Auditor fee	50,000	0	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 costs (5,000 B x 2 persons x 2 times)	20,000	20,000	40,000		1%
4. Immigration (2,000 B x 8 time x 2 persons)	32,000	0	32,000		1%
5. Attending local coordination meetings	50,000	50,000	100,000		3%
6. Computer (Desktop/Laptop) 3 Sets (30,000 B x 3 Sets)	90,000	0	90,000		3%
7. Meeting hall Renovation	70,000	0	70,000		2%
8. Dealing with border committee (3,000B x 6+6 mths)	18,000	18,000	36,000		1%
9. Distance transportation (15,000 B x 6 + 6 mths)	90,000	90,000	180,000		6%
10. Emergency Healthcare	100,000	100,000	200,000		7%
11. Security cost (3,000 B x 6 + 6 mths)	18,000	18,000	36,000		1%
12.Local transportation (5,000B x 6+6 mths)	30,000	30,000	60,000		2%
Total Other Administration Costs	**608,000**	**366,000**	**974,000**		**32%**
Total Administration	***1,713,000***	***1,301,000***	***3,014,000***	***7.2%***	***100%***
Grand Total for All Programs in 2011	**20,534,200**	**21,077,300**	**41,611,500**	**100%**	**100%**