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

2013 Proposal
Back Pack Health Worker Team

2013 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: :	**200,000** people living within the Mon, Kayah, Kayan, Karen, Shan, Kachin, Pa O and Arakan areas
Project Duration:	January to December 2013
Budget requested:	**45,469,400** Thai Baht
Organization:	Back Pack Health Worker Team (BPHWT) P.O Box 57, Mae Sot, Tak, 63110 ,Thailand
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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, marginalized ethnic groups began to take up arms in the country's border regions in pursuit of increased autonomy. In addition to long-running instability in these areas, a military coup in 1962 led by General Ne Win marked the start of almost six 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 recent internationally heralded "reforms" undertaken by President Thein Sein's government, these changes have not yet manifested into substantial sustainable change on the ground.

The seventeen-year old ceasefire between the government of Burma and the Kachin Independence Organization (KIO) was broken in 2011 and has driven the displacement of over 70,000 internally displaced persons (IDPs) and refugees to the China-Burma border. Even as intense fighting continues in Kachin State, the government of Burma has pursued preliminary ceasefire and peace agreements since the end of 2011 with various ethnic groups in Chin, Arakan, Mon, Karen, Karenni and Shan States. Incidences of armed conflict have decreased significantly since the signing of these initial peace agreements, but fighting has continued in some ceasefire areas, particularly in Shan State. The government of Burma has prioritized development over political dialogue and inclusion, with the lull in fighting prompting incidences of land confiscation to increase exponentially in the ethnic resource-rich regions. The Burma Army (Tatmadaw) and their allied armed groups have been forcibly displacing civilians from their homes and confiscating land from villagers at a rapid rate for development projects and/or military camps, while providing the villagers with little or no compensation. The bulk of the

Gold mining in Kyaukkyi, Karen State

development projects are resource extractive projects (i.e. hydropower dams, logging, mining, etc) and are proceeding often without the consultation of local community members and without valid environmental, health and social impact assessments, which is causing legitimate concern among community members that these projects will negatively affect them over the long-term.

Moreover, in the conflict and current ceasefire areas, the Burma Army and its allied armed forces continue to routinely commit widespread human rights violations against ethnic civilians. These widely documented abuses include forced labor, confiscation and destruction of food supplies, arbitrary taxation, torture, land confiscation, rape, and extrajudicial execution. These ongoing abuses demonstrate that the peace talks have not significantly improved the situation on the ground and that in order to achieve a meaningful, durable peace, the Burma government must be committed to resolving the underlying political and socioeconomic issues driving conflict in the ethnic border regions. The BPHWT recognizes the fragile nature of the peace process and how previous peace agreements have broken down; consequently, BP health workers will continue to take security precautions while traveling and providing health services until a genuine political dialogue and change occur.

(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 socioeconomic policies of the past and continue to chronically disregard basic essential social services. Despite almost $20 billion of approved foreign direct investments in 2011, which is more than the previous two decades combined[1], the regime spends around $17 per capita in 2010 on health, amongst the lowest in the world. According to the United Nations Development Program's development index[2], Burma spent less than 2% of total GDP in 2010 on health, leaving Burma in the 149th position in the United Nation's Development Program's Human Development Report for 2011[3]. Burma is thus lagging far behind the UN's Millennium Development Goals (MDGs).

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[1] Bissinger, J. (2011). Behind burma's rising fdi. *The Diplomat*, Retrieved from http://thediplomat.com/asean-beat/2011/08/31/behind-burmas-rising-fdi/

[2] UN Human Development Report, 2011

[3] UN Human Development Report, 2011

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 50 per 1,000 live births in 2010, with an under-five mortality rate of 66 in the same year[4]. These figures also suffer highly unfavorable comparisons with the recorded infant and child mortality rates of Thailand for 2010 at 11 and 13 respectively[5].

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 IDPs within Burma is even more serious cause for concern. Health indicators for the rural ethnic populations in eastern and southeastern 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

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.

[4] UNICEF Myanmar Statistics, 2010

[5] UNICEF Thailand Statistics, 2010

In 2010, BPHWT published a report entitled ***Diagnosis Critical***[6]**,** 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 Burma 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**.** 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 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 the assistance of a traditional birth assistant (TBA). In unstable environments, it is not uncommon for internally displaced women to deliver their baby in

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[6] 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.

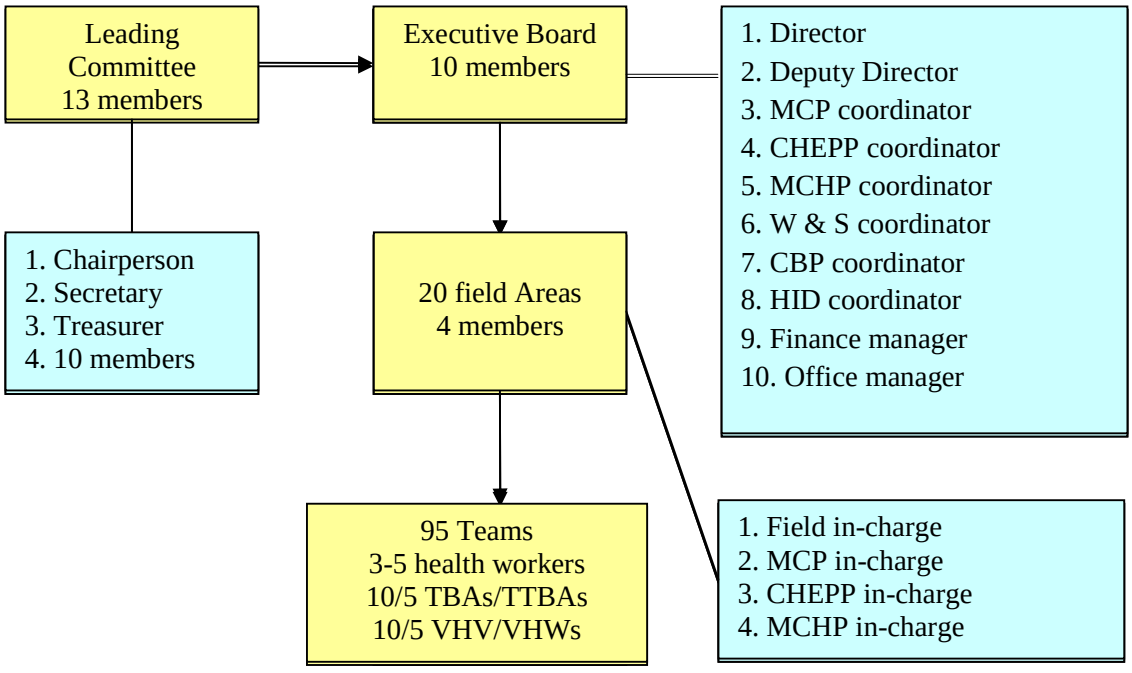
Diagnosis: Critical – Health and Human Rights in Eastern Burma, Consortium of border based health organizations, October 2010.

the jungles located deep inside Burma, while hiding from the Burma army patrols. Overall, only 4% of IDP women had access to emergency obstetric care. 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.

II. Back Pack Health Worker Team

The BPHWT was established in 1998 by Karenni, Mon and Karen health workers to provide healthcare to IDPs, living along the eastern border of Burma, affected by many decades of civil war. In 2012, the BPHWT provided primary healthcare in 20 field areas with 95 teams to a target population of over 200,000 people. There are currently over 1,500 health workers, living and working in Burma, connected with the BPHWT consisting of 331 medics, 780 TBAs and 403 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 Committee which is elected every three years by the BPHWT members. The Leading Committee is comprised of 13 members who serve a three year term. The Leading Committee appoints an Executive Board of 10 members. This Executive Board is required to meet monthly and make decisions on current issues and planned activities of 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 Committee, amendments to the 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, program 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 of Workers
2000	BPHWT (Community-based primary healthcare unit)	BPHWT Health Worker	1:500	4
		Traditional Birth Attendant/Trained Traditional Birth Attendant	1:200/400	10/5
		Village Health Volunteer/Village Health Worker	1:200/400	10/5
Total Members Per Team				**24/14**

(iv) Gender Policy and Analysis: In 2011, fifty-five percent of the BPHWT staff was composed of women, excluding TBAs and TTBAs. 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 2011

Category	Total # of Workers	Total # of Females	Females Actual %	Females Target Minimum %
Leading Committee/Executive Board	14	6	43%	**30%**
Office Staff	11	4	36%	**30%**
Field Management Workers	54	28	52%	**30%**
Field Health Workers	264	113	43%	**30%**
Traditional Birth Attendants/Trained Traditional Birth Attendants	722	626	87%	**Target not set**
Village Health Volunteers/Village Health Workers	426	289	63%	**30%**
Total Organization	1527	1066	70%	**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 2011, the BPHWT treated about **80,630** 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 Guidelines (BBG). The Health Information and Documentation Program collects and analyzes the health data and provides refresher courses for health workers (assisted by international consultants from partner organizations), and forms the main content of 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

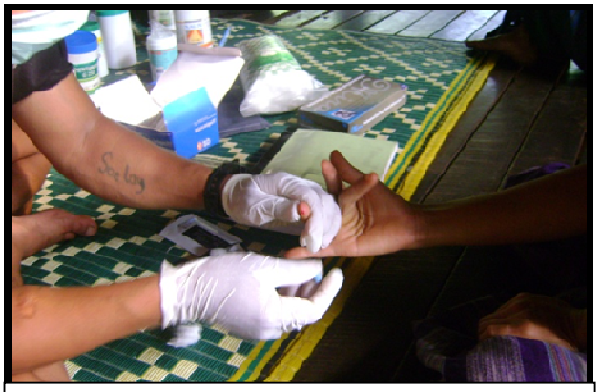
MCP Activities:

- Increase the number of BP teams
- Provide medicine and medical supplies
- Treat common diseases and minor injuries
- Provide ITNs, malaria rapid diagnosis tests (RDTs) and ACT medicine
- Purchase emergency medical supplies and immediately take action
- Organize six-monthly workshops and field workshops
- Refer patients to the nearest hospitals or clinics

MCP Strategy & Methodology:

- BPHWT selects target areas based upon community requests and other criteria outlined in the BPHWT constitution, including that at least two experienced health workers from the community must be available and willing to form a BP team in the requested target area. In each target area, the MCP will focus on the six most prevalent conditions: malaria, ARI, diarrhea, dysentery, anemia and worms. Within each six month term, each BP team must go to each village in their BP tract at least two times; and BP health workers must spend at least three days in each village.

- To prevent and decrease incidences of malaria, insecticide-treated mosquito nets (ITNs) will be provided, but ITNs cannot be provided for the entire target population. Therefore, providing ITNs will be prioritized to households with pregnant women and children under five years of age. In order to confirm cases of *Plasmodium falciparum* (Pf) malaria, the BPHWT began using small, portable Rapid Diagnosis Tests (RDTs) in 2005. At that time, there weren't sufficient amounts of RDTs available to cover all field areas but by 2009, all target areas were provided with these RDT kits, and the BPHWT began to give first-line malaria treatment to patients according to the BBG protocol. However, there is still a significant caseload of presumptive *Plasmodium vivax* (Pv) malaria since RDTs only check for Pf malaria.



Using RDT testing for malaria PF

- In an effort to combat the drug-resistant malaria prevalent in the target areas, the BPHWT has adopted WHO recommended Artemisinin-based combination therapy (ACT) as first-line treatment for malaria. However, due to the challenges of high-quality medicine procurement in Thailand and Burma, the BPHWT is unable to purchase and provide pre-combined fixed-dose ACT tablets. Therefore, artesunate and other malaria medicines such as mefloquine, quinine and doxycycline must be purchased separately and the health workers must be trained on how to combine them when administering first-line treatment, and on the appropriate combinations for various patient scenarios.

- Although the BBG has not been updated since 2007, the BPHWT will update treatment protocols according to newly released WHO recommendations at every six month meeting.

- The BPHWT will purchase emergency medical supplies and immediately take action in cases of emergency humanitarian situations as outlined in the BPHWT constitution, such as natural disasters, epidemics, armed conflicts and famine.

- Every six months, the BPHWT field in-charges and program in-charges of each field area must report to the main office to share their data, participate in the general meeting and attend workshops. During the general meeting and workshops, all participants will discuss updating protocols and responding to challenges, and upgrade skills and knowledge. Afterwards, the in-charges will head back to their target areas and conduct field workshops for the health workers in their field area, and update them on the meeting decisions and new treatment protocols.

- The BPHWT tries to refer serious cases to the nearest clinic or hospital, but referrals are constrained by security concerns, physical environment challenges, availability of clinics and hospitals, and high transport and hospital costs. However, the referral system is improving as BP health workers are becoming more skilled at recognizing emergency danger signs and referring patients earlier, as the security situation improves in some ceasefire areas allowing more freedom to travel, and as infrastructure links are improving.

(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, especially the prevention and control of communicable diseases such as Lymphatic Filariasis (LF). Capacity building occurs through peer education trainings in schools and Village Health Workshops. The Water and Sanitation sub-program provides gravity-flow water systems to communities. The School Health sub-program distributes Vitamin A and de-worming medication, builds safe water supplies, and constructs latrines in schools. The Village Health Workers sub-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. In order to improve community accessibility of health services, the BPHWT has set a target to recruit five Village Health Workers (VHWs) for each BP team so that they can assist the mobile health workers in monitoring patients and providing basic medical care when the health workers are not in the vicinity, with each VHW serving a population of about 400 people. In the past, ten Village Health Volunteers (VHVs) were recruited and provided with a month of training. Currently, the BPHWT is upgrading the VHVs' skills to become VHWs and recruiting new VHWs. The VHW training is three months long and will give them the skills to help treat the three main diseases in BPHWT target areas: malaria, acute respiratory infection and diarrhea. One of the most important responsibilities of VHWs is ensuring that anyone with a fever gets a malaria test within 24 hours.

Village Health Worker Training in Thaton Area

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 de-worming medicine to children between the ages of 1 to 12 years old and Vitamin A to children between the ages of 6 months to 12 years old
- Provide school health education, village health workshops and health campaigns
- Organize Village Health Worker trainings and workshops
- Provide VHW kits
- Provide Water and Sanitation systems

- Provide Mass Drug Administration among the community and educate community members about Lymphatic Filariasis through LF awareness workshops

CHEPP Strategy & Methodology:

- Every six months, a BP health worker coordinates with the VHV/VHW and Village Health Leader to gather all children in the village to provide vitamin A and de-worming medicine. The VHVs/VHWs will take charge of providing vitamins to the children, recording each child's intake of supplements and other medicines, and monitoring each child's health status. Around 10,000 children will benefit from this intervention.

- Through school health education, a total of around 50,000 students will be oriented on Water and Sanitation Hygiene (WASH) by the BP health workers. The School Health Sub-Program is an aspect of the CHEPP which uses a child-to-parent model to influence not only the health awareness, behavior, and practices of the student, but also that of the parent through the student. The students are also provided with personal hygiene kits which include toothpaste, a tooth brush, nail clippers, and scissors to cut hair. They are taught the proper use of these items. The BPHWT's school health education sessions provides the students with information about malaria prevention, diarrhea prevention, hygiene, nutrition, influenza awareness, HIV/AIDS education, and drinking water systems. Filter systems linked to a large water dispenser are placed in the schools so that school children will have access to clean drinking water.

Providing water filter systems in school

- BP health workers must conduct three Village Health Workshops in their BP tract each six-month term. The aim of these workshops is to provide the community with health education, identify community problems, and brainstorm solutions through a Participatory Learning and Action (PLA) approach. Health workers must raise the community problems and solutions at

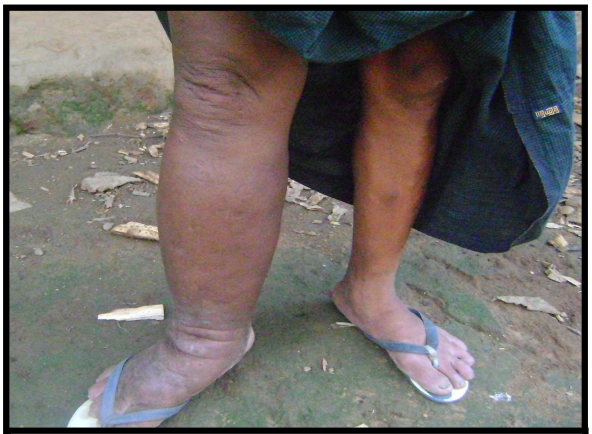
each six-month field meeting and subsequently, the field in-charges raise the collective issues at the following six-month general meeting for discussion and future planning.

- The BPHWT health campaigns focus on raising awareness about HIV/AIDS. On World AIDS Day on December 1st, BP health workers in all field areas will organize events to promote awareness and reduce cultural stigma of HIV/AIDS. In addition to HIV/AIDS, other public health issues are also discussed. Pamphlets are used to promote safe health practices.

- Since VHVs and VHWs must stay in villages to help the health workers monitor patients, provide health education and other basic health care, they are provided with VHW handbooks and VHW kits which contain medicines and supplies for the VHWs to treat the common illnesses of malaria, ARI and diarrhea, as well as vitamins and basic first aid supplies.

- Gravity-flow water systems and protected shallow wells will be constructed in the targeted areas with the help of external technical specialists and the community members. The VHVs/VHWs supervise the construction together with the villagers. In the BPHWT areas, the water systems are maintained by the community members themselves. The Village Committees, composed of the village leader and 7 to 11 respected members of the community, will be responsible for ensuring the maintenance of the water systems and for deciding and coordinating community activities.

- Mass Drug Administration (MDA) and education about Lymphatic Filariasis (LF) is provided to the community members. As part of its core prevention program, the BPHWT will provide MDA of DEC and albendazole to each villager in the selected areas of the LF pilot program. Currently, there are five LF areas covered by BPHWT: two in Papun, two in Kler Lwee Htoo, and one in Thaton. Those who are suffering from the disease will receive the medication twice a year. BP health workers are responsible for monitoring the LF MDA.



Lymphatic Filariasis patient in Papun

(iii) Maternal and Child Healthcare Program (MCHP):

The MCH Program aims to improve the health of women and children, ensure safe deliveries, and provide family planning advice and contraceptive supplies to people within the field areas. A two-tiered system is utilized, but it is important to emphasize the integrated nature of this approach. Back Pack health workers are the primary providers of medical services in their target areas, while community chosen Traditional Birth Attendants/Trained Traditional Birth Attendants (TBAs/TTBAs) receive additional training from BP health workers. This training introduces the TBA/TTBA to (or reviews) important elements of pre- and postnatal care, clean delivery and aseptic technique, family planning counseling, and emergency obstetric care (EmOC).

In the Maternal and Child Healthcare Program, capacity building is delivered through the six-monthly Reproductive Health Workshops attended by MCH Supervisors, 20-day TTBA training courses and 3-day TBA/TTBA workshops every six months in field areas. The BPHWT has had specific criteria to recruit new TBAs; the TBAs must have had the experience of delivering at least five babies and must have attended at least two TBA workshops. Additionally, they must be recommended by the communities. As a result, the TBAs who are working in the MCHP already have the experience of delivering five babies or more and are trusted by the communities. However, the number of TBAs is dwindling as most of the TBAs are old and there is a decline in new recruitment due to BPHWT's strict criteria.

TBA workshop in the field area

Consequently, the BPHWT has initiated a new standard in 2012 and to start TTBA training to recruit new younger people, and upgrade the former TBA training with a longer and more advanced curriculum. Moreover, in one of BPHWT's efforts to lead the convergence of the extensive border-based health system with the government of Burma's health system, the BPHWT plans to enroll and support forty trainees for two state-administered Auxiliary Midwife (AMW) trainings in Karen State, and will facilitate the standardization of BPHWT and the state administration curricula. Upon completion of this training, the AMWs will

work for the BPHWT and implement MCH programs in their respective areas, while being supervised by a midwife appointed by the state administration.

TBAs/TTBAs have access to and regular communication with Back Pack medics for the majority of the time. Twice a year, MCH field supervisors travel to the BPHWT headquarters for activity reporting, resupply and workshops. Where there is no stable clinic setting, the interventions with the greatest potential to decrease the maternal mortality rate (MMR) are not feasible, hence, the BPHWT accordingly focuses on the most effective interventions that can be implemented in a mobile community-based setting. Working together, the TBAs/TTBAs and medics increase people's access to important maternal and child healthcare. These include interventions for reducing neonatal and infant mortality (i.e. iron/folate distribution, clean delivery, etc) and services that contribute to the reduction of MMR, such as the provision of safe deliveries and the referral of EmOC cases.

MCHP Objectives:

- Increase maternal and child healthcare
- Raise awareness among the community on family planning and provide them with family planning supplies
- Improve the knowledge and skills of TBAs/TTBAs and MCHP supervisors
- Provide delivery records
- Converge and coordinate with the Burma government's state-administered Reproductive Healthcare program in Karen State

MCHP Activities:

- Distribute iron tablets and de-worming medicine prenatally and postnatally to pregnant women, and Vitamin A to postpartum women
- Refer serious obstetric cases
- Provide antenatal care (ANC) to pregnant women
- Provide obstetrics gynecology (OG) instruments to skilled MCH workers
- Provide family planning supplies and education
- Conduct TTBA training and TBA/TTBA workshops
- Provide safe birthing kits
- Document deliveries
- Organize Auxiliary Midwife (AMW) training

MCHP Strategy & Methodology:

- TBAs/TTBAs are trained to identify risk factors and danger signs to facilitate early referral to a health worker, or the nearest clinic - whichever is more easily accessible. However referral will often be constrained by security challenges, physical environment challenges, availability of clinics and hospitals, and high transport and hospital costs.

- ANC requires at least four visits by the MCHP worker and/or TBA/TTBA and includes malaria screenings; general examination; monitoring of danger signs; nutrition, hygiene and family planning education and counseling; and the provision of a maternity kit.

- Postnatal care (PNC) requires at least three visits by the MCHP worker and/or TBA/TTBA and includes: puerperium care, neonatal exam, issuance of delivery certificate, education and counseling (breastfeeding, infant care, nutrition, hygiene and vaccination etc).

- OG instruments for safe deliveries will be provided to MCH workers who have completed the MCH refresher training course.

- Family planning supplies such as condoms, the contraceptive pill and the contraceptive injection will be provided by the MCHP health workers to communities which request these services. MCHP health workers will distribute around 30,000 condoms in their areas under the knowledge and skills of TBAs/TTBAs and MCHP supervisors.

- Since TBAs are being phased out, only TTBA trainings will be conducted, but TBA workshops will continue until all TBAs have been upgraded to TTBAs. In rural Burma, TBAs/TTBAs are usually the first ones who help pregnant women and their families with the delivery of their babies. In many areas where midwives are not available, in part due to the fact that they are not trusted by the community if they are not from within the community. The TBAs/TTBAs are at the forefront for ensuring the sustainability of local reproductive healthcare. It is thus important that the skills of TBAs/TTBAs are improved so they can perform safe and aseptic deliveries and provide proper maternal and reproductive healthcare to these vulnerable communities. The TTBA training will target previously trained TBAs and TBAs who have had significant years of practical experiences in child deliveries. As they

already have practical experience and knowledge, the aim is to enhance their skills and knowledge in sterilization and accepted aseptic techniques. The training will focus on providing safe delivery under aseptic conditions and will correct any misconceptions or misguided practices they might have. The training will also help develop and build upon the pre-existing extensive skills and experience of TBAs who are respected by their communities for their indigenous knowledge. These skills have been acquired through apprenticeship and/or on-the-job training in a local community, and typically passed on from generation to generation. The training will teach participants how to cut umbilical cords in a sterile procedure, when to provide pregnant women with iron and folic acid, and how to detect early high-risk or difficult pregnancies. Training will also include antenatal care, intranasal (delivery) and PNC for mothers and infants, referral systems for difficult pregnancies and other conditions, neonatal care, nutrition, delivery records, vaccination/immunization, health education, and breastfeeding. Training also focuses on educating and breaking traditional misconceptions related to pregnancy that communities often harbor.

Providing a TBA/TTBA training

- Each participant of the TTBA training will be provided with a TTBA kit that is similar to the kit given to a midwife within the government structure. This will help ensure a safe and aseptic delivery.

- In addition to the TTBA kits, maternity kits containing tools and medicines like folic acid, vitamin A, cotton, povidone, albendazole, and pack of plastic bags to ensure a healthy pregnancy and postnatal conditions will be distributed by BPHWT to all TBAs/TTBAs. Given that in these rural areas in Burma, most births are assisted by TBAs, access to this kit helps to ensure safe and aseptic conditions. All TBAs/TTBAs are trained in the use of this basic equipment.

- All deliveries will be documented by TBAs/TTBAs and MCHP workers. The BPHWT asks mothers to keep a copy of their child's delivery record so that the child may have possible citizenship if the political and security situation changes in the future, which will entitle children to access formal education and to get national ID cards. If the mothers' copy is lost or destroyed, the BPHWT also maintains a copy of all delivery records at the central office.

- AMWs are trained and recognized by the state administration, and also have more advanced training than the BPHWT TBAs. They assist midwives with clinical work; controlling communicable diseases; providing domiciliary care of pregnant women and postnatal care; providing domiciliary delivery of normal labor cases; providing environmental sanitation education, health education and nutrition promotion; collecting vital statistics; and recording and reporting births. Since midwives and AMWs are trained and recognized by the state administration, they can travel freely and much more securely than the BP health workers and TBAs/TTBAs. This health convergence initiative has begun with the BPHWT negotiating with Burma government Township Medical Officers in Karen State to help enroll twenty recruits for each AMW training (two trainings in 2013). The community health development committees in each township will manage the training while state-appointed midwives will conduct the training in coordination with the Pa An hospital. Each Midwife Trainer has a Midwife certificate, at least three years of teaching experience, training and supervision skills, fluency in Burmese and Karen, and understanding of the situation of the areas with difficult access. The BPHWT support will include contributing funding for the training, reviewing and revising the curriculum, and facilitating the standardization of the BPHWT and the state administration curricula. The focal point of standardization will be upgrading the current AMW curriculum in order for AMWs to perform deliveries and not just assist midwives, which is the current government policy. Once the AMW curriculum and training is changed, then AMWs will be more skilled and knowledgeable than BPHWT TBAs/TTBAs. Upon completion of this training, AMWs will commit to working and living in their communities in order to implement a MCH program in their respective areas, while working under the supervision of state-appointed midwives. Financial support for this health convergence initiative will initially come from award earnings from Stichting Vluchteling's Van Heuven Goedhart Award to the current BPHWT Director, Saw Win Kyaw. This prestigious award honors the work of a notable refugee or IDP and was previously awarded to the BPHWT Chairperson, Dr. Cynthia Maung. Part of the prize money will support the

two AMW trainings, but future AMW trainings will be supported through the BPHWT's core funds. If this initiative is successful, the BPHWT plans to upgrade all TBAs/TTBAs to become AMWs in Karen State and other BPHWT target areas.

- AMW training will be four months long, followed by a three month practical which will take place in the township's Rural Health Center under the supervision of a state-appointed midwife. Afterwards, the AMWs will be supervised by the midwives and implement MCH programs in their respective areas. One AMW will serve a target population of about 400 people.

(IV) 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 MCHP supervisors, TBA trainers, other BP health workers and invited technical consultants from NGOs and INGOs. The BPHWT also organizes community health worker and refresher training courses, in collaboration with local health organizations and short management courses for office staff. .

CBP Objectives:

- Improve health workers' and staff members' knowledge and skills
- Promote gender equality in leading positions

CBP Activities:

- Conduct Community Health Worker (CHW) Training-of-trainer (ToT), Village Health Worker (VHW) ToT, TTBA/MCH ToT, MCH refresher, and Medical refresher
- Attend international and local conferences and meetings
- Attend international and local short course training
- Attend project management and organizational development training
- Regularly review and adopt gender policies
- Hold the BPHWT general election triennially

CBP Strategy & Methodology:

- An important aspect of BPHWT's capacity building is to attend local and international conferences and trainings to gain knowledge and skills to become more self-sufficient; and also raise public awareness of the BPHWT and advocate on the larger health issues of Burma.

- The BPHWT aims to improve equity for women across all levels of the organization and therefore sets a target to have a minimum of thirty percent of women at each organizational level.

- Every three years, the BPHWT will hold a general election for leading positions such as the Leading Committee, health program coordinators, and field in-charges.

(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 like calendars and cameras
- Analyze data collected by BP health workers
- Organize field training and/or workshops aimed at standardizing case-definition data collections

- Produce health information, education, and communication materials for Village Health Workshops
- Organize Health Program Coordination and Development Seminars

HID Strategy & Methodology:

- Health information and documentation training is crucial to the functioning of community-based health organizations. The BPHWT builds the capacity of its staff by providing training in indicator development, data form design, data management, and data analysis in order to conduct regular monitoring and evaluation activities.

- The BPHWT has been conducting regular HID training in Mae Sot and other border areas for many years. The BPHWT intends to continue to conduct annual and monthly workshops to build capacity for standardizing case definition data collection. Additionally, as staff becomes more evidence-based driven, additional skills are needed for program staff and the HID Coordinator to understand how to determine their data needs and then how to interpret and use it.

- A majority of the IDPs are prone to gastrointestinal diseases partly because of unhygienic practices and limited knowledge of the effects of these practices on their health. To address this, the VHVs/VHWs and BP health workers will provide families with WASH education, focusing on the maintenance of latrines, consumption of potable water, water-related diseases, and other topics. The VHVs/VHWs and BP health workers will ensure that the information is culturally sensitive and appropriate to the conditions of the IDPs. Existing information and materials from the government and other groups on these topics will be reproduced and provided.

- 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.

IV. Health Convergence Initiative

Spurred by the ongoing peace process in many ethnic areas of Burma, the BPHWT and other health CBOs and ethnic health organizations have been working to converge the extensive border-based health system with the Burma government's health system in order to provide better healthcare, access more of the population, improve health system and policy, and gain government recognition of border-based health programs and workers. Over the past decade, the government of Burma has spent less than 3% of its national budget annually on healthcare and as a result, the healthcare system is rather inadequate, particularly in rural areas. In contrast, over the last twenty years, international aid agencies and donors have invested heavily and successfully in building the capacity and network of the border-based health system, which includes trainings, clinics, mobile clinics, health services, monitoring and evaluation etc inside Burma. As opposed to starting anew to build capacity and develop the health system in Burma, numerous BPHWT donors/partners (i.e. DfID, Christian Aid, BRC, GHAP, Stichting Vluchteling) are supporting BPHWT convergence initiatives to work with Yangon-based health organizations and township medical offices in order to expedite the improvement and development of Burma's health system by taking advantage of the extensive knowledge, access and network of the border-based health system. This is a slow process because convergence needs to occur at the system, policy, structural and program levels, but BPHWT has already began initiation by hosting the first Health Program Convergence Seminar in July 2012 where state-appointed midwives and health CBOs and INGOs based in Yangon came to Mae Sot to coordinate program convergence with border-based health CBOs and ethnic health organizations. Health Program Convergence Seminars will be held at least twice a year starting in 2013. In addition, the BPHWT has been implementing a DfID-funded convergence project with health CBOs based in Yangon, while the initial AMW trainings will be funded by Stichting Vluchteling. As the BPHWT moves forward with convergence at the program level, convergence at the policy, system and structural level will develop in conjunction with and after the peace process and durable, meaningful political change occurs during this transitional period in Burma.

Health Program Convergence Seminar

V. 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 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 organizations, such as the Karen Department of Health and Welfare (KDHW), Shan Health Committee (SHC), Mon National Health Committee (MNHC), and Karenni Health Department (KnHD); and other CBOs, NGOs and INGOs based inside Burma. 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; and by the International Recue Committee (IRC) for medical technical support and organizational capacity building.

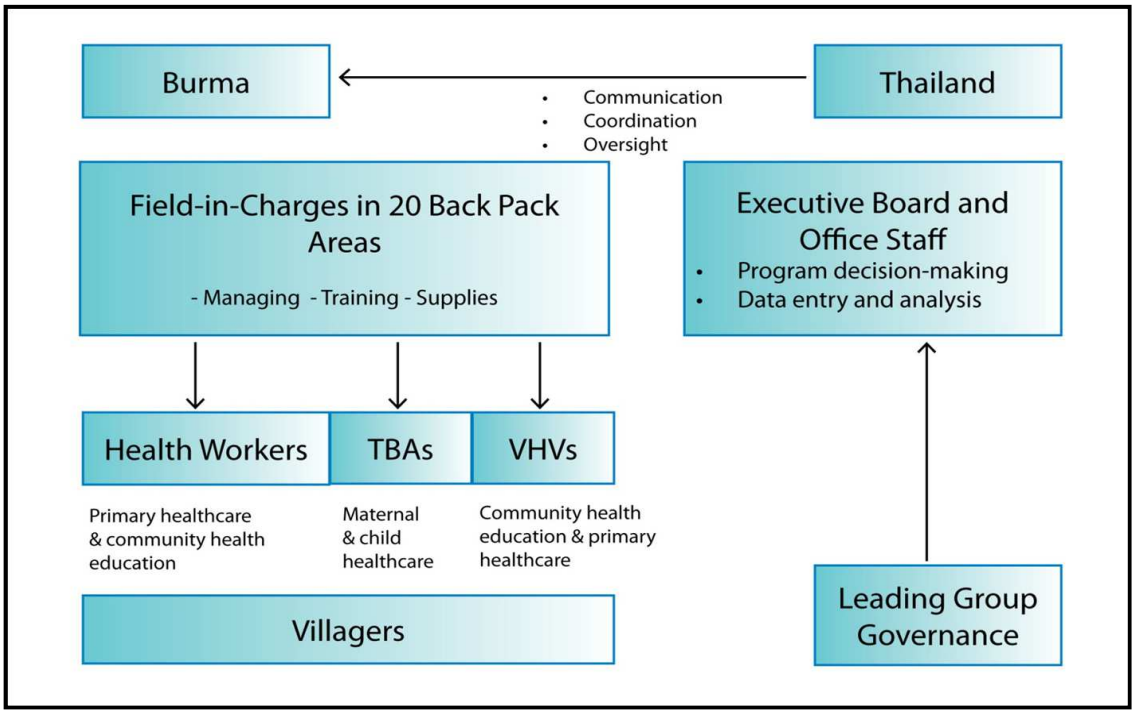
BPHWT Semi-Annual meeting in Mae Sot

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.

VI. 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, such as 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.



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 a year	- 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, to constantly assess the effectiveness and impact of our programs. Internally, our monitoring and evaluation covers three areas: program management, program development and program effectiveness. Data collection and analysis is a vital part of BPHWT's monitoring systems for each of these three areas. Every six months, field in-charges submit caseload data from the filed logbooks to the program coordinators and HID staff in the central office, which is later analyzed and presented in the general meeting that is held every six months. In addition to reviewing caseload information, the participants also discuss challenges, discuss treatment protocol updates and make decisions and changes to programs. In order to monitor program management, the health workers' performance is regularly

Entering the data to the database

reviewed. Additionally, field in-charges regularly meet with village leaders and community members to get feedback on programs and to monitor their local health needs. Lastly, the BPHWT carries out an Impact Assessment Survey every two years using clusters of randomly selected households in most field areas. This survey assists the BPHWT in reviewing program activities, evaluating program effectiveness and planning for future activities. In addition to our internal monitoring, the BPHWT is also regularly evaluated by donors and sometimes independent external consultants. In 2011, the Thai Burma Border Consortium (TBBC) and the IRC carried out a monitoring visit to BPHWT target areas and found that the monitoring and evaluation systems in Eastern Burma are among the most reliable in conflict zones in the world. The table below summarizes the current Monitoring and Evaluation framework:

Activities	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 Committee - Fields in-Charge	Annually	Comparison and reasons for variance included in the annual report
Effectiveness of VHW & TTBA 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	- 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 Committee - Fields in-Charge	6 monthly	Comparison and explanation of variances included in the 6 month 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

VII. Map of Operational Areas

VIII. Logical Framework of BPHWT Programs in 2013: The BPHWT programs and descriptions of the activities, indicators of achievements, verification sources, expected outcomes and the assumption or risks involved in the delivery of the programs.

Overall goal	To reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare						
OBJECTIVES	**ACTIVITIES**	**INDICATORS OF ACHIEVEMENT**	**VERIFICATION SOURCES**	**2013 EXPECTED RESULTS**	**2013 ACTUAL RESULTS**	**VARIANCES OR DIFFERENCES**	**ASSUMPTION OR RISKS**
Medical Care Program							
1. Provide essential drugs and treat the common diseases	Increase number of BP teams	No. of teams increased	Procurement delivery documents; logbooks; analysis of data collected; and field reports	BP teams will be increased from 95 to 100			
	Provide medicine and medical supplies	No. of target population and total case-load (w/m), under/over 5)		200,000 targeted population			Can be more targeted population
	Treat common diseases and minor injuries	No. of cases treated (w/m, under/over 5)		108,000 cases being treated (no. of families & HH, no. of w/m and under/over 5)			
	Provide ITNs	No. of ITNs provided and no. of HHs and people receiving ITNs	ITNs distributing lists	7,000 ITNs will benefit 7,000 HHs or 35,000 people			
		Percentage of people in households sleeping under	2013 Impact Assessment Survey	60% of people in households sleeping under ITNs			

		ITNs (Baseline-53%)					
	Provide malaria rapid tests	No. of malaria rapid tests provided	Rapid tests distributing lists	32,700 rapid tests will be provided			
	Provide ACT to patients with malaria	Number of (CASES) women and men diagnosed with PF malaria by the BPHWT who are treated with ACT in the BPHWT target population(baseline – W-3103,M - 3606 Total: 6709 individuals in 2010)	Health worker logbooks; field in-charge reports; midyear and annual report	Women – 4,000 Men - 4530 Total: 8,530 individuals			
		Percentage/Number of children (CASES) under 5 treated by BP health workers who receive appropriate anti-malarial treatment	Health worker logbooks; field in-charge reports; (malaria data analysis)	95% of children under 5 treated who receive appropriate anti-malarial treatment.			

		Malaria mortality rates per 1,000 population (baseline-3.5 malaria case deaths per 1000 population)	2013 Impact Assessment Survey	2.5 malaria mortality rates per 1,000 population			
		Mortality rates among children under 5 years old per 1,000 live births in target population (baseline-138)	2013 Impact Assessment Survey	130 mortality rates among children under 5 year old per 1,000 live births in target population			
		Percentage of under 5 children with malnutrition (according to accepted guidelines for MUAC cutoffs) (Baseline – 16.5%)	2013 Impact Assessment Survey	14% of under 5 children with malnutrition			
2. Respond to disease outbreaks and emergency situations	- Purchase emergency medical supplies and immediately take action	Prompt reporting Population affected No of cases treated (w/m, under &	Delivery document; field reports; exception reports; annual	-Effective response and treatment for disease outbreaks or emergency situations (w/m &			

		over 5)	report	under/over 5			
3. Improve health workers skills and knowledge	Organize Field meetings and workshops	No. of health workers participated	Field meeting and workshop report	Twice a year for 20 areas			
		No. of participants		200 people participate in field workshop and 200 in meeting			
	6 month workshops	No of health workers participated	Workshop report; mid year and annual report; workshop attendance list	120 health workers attend 6 month workshops(w/m)			
4. Improve patient referral systems	Refer patients to the nearest hospitals or clinics.	No of referrals patients(w/m) List of referral sites	Mid year and annual reports; patient's referral for	90 patients referred to clinics or hospitals (w/m)			
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	No of children receiving de-worming medicine	Worker data form; mid year & annual	40,000 children will receive de-worming medicine			

	Distribute Vitamin A to children between the ages of 6 months to 12 years	No. of children receiving Vitamin A	reports	42,000 children will receive Vitamin A			It can be changed according to the revise of the protocol and guideline of Vitamin A distributing
2. Educate students and communities about health	Provide school health education	No. of school sessions and no. of students (w/m)	Field reports; mid year & annual report	95 school sessions attended by 9,500 students (w/m)			
	Provide Village Health Workshops	No. & category of people in Village Health Workshops (w/m)		13,300 people participate in 95 sessions Village Health Workshops			
	Provide health campaign	No. of people participate in event (w/m), (World AIDS Day)	Village Health Workshop reports	95 World AIDS events for 14,250 people			
3. Improve community level knowledge and participation in health	Organize village health worker trainings and workshops	No. training and VHW attended (w/m)	Field report; mid year & annual report; VHW training and workshop reports	20 VHW trainings for 400 new VHWs (w/m)			
		No. workshop and VHW participate (w/m)		160 VHW workshop for 500 VHWs (w/m)			

	Provide VHW kits	No. of VHW kits provided	VHW kits distributing list; field, mid year & annual reports	160 VHW kits will be provided for 500 VHWs			
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 benefit from latrines	Field reports; mid year & annual report	100 school latrines will be benefited 2,000 students			
				3,000 community latrines or will be benefited 30,000 populations			
		No. & type of water systems installed		20 gravity flow water systems 1,200 house-holds (6,000 pop)			
		No. of HHs and people benefit from water systems (w/m)		60 shallow well systems 600 house-holds (3,000 pop)			
		% of people who own a latrine using latrines (always and sometimes) (Baseline -98%)	2013 Impact Assessment Survey	99% of people who own a latrine using latrines (always and sometimes)			

		% of people who own a latrine (Baseline - 70% in 2010)		80% of people who will own a latrine			
5. Prevent and control communicable disease of Lymphatic Filariasis	Provide Mass Drugs Administration for among the community	No. of people receive drug (w/m & under/over 5)	Field reports; midyear & annual report	13,100 people will receive Albandazone and DEC. (w/m & under/over 5)			
	Provide awareness workshop	No. of participants	LF workshop attendance list	5 awareness workshop to 1,500 (w/m) population			
Maternal and Child Healthcare Program							
1. Increase maternal and child healthcare	Distribute Vitamin A and Albandazole	No. of pregnant women receiving Albandazole and no. of postpartum women receiving Vitamin A	TBA's form	4,000 pregnant women will receive Albandozole and 4,000 postpartum women will receive Vitamin A			It can be changed according to the revise of the protocol and guideline of Vitamin A distributing
	Provide iron prenatally and postnatally to pregnant women	No. of pregnant women and women receiving iron		4,000 pregnant women and women will receive iron			
	Referral of serious obstetric cases	No. of serious obstetric cases	Patient's referral form; mid year &	20 obstetric cases referred			

			annual report				
	Provide ANC to pregnant women	No. and % of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010)	2013 Impact Assessment Survey	50% of pregnant women in target population with at least four ANC			
		% of children 0-5 months who are fed exclusively with breastfeeding in target population (Baseline -23%)	2013 Impact Assessment Survey	30% of children 0-5 months who are fed exclusively with breast milk in target population			
		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(Baselin	2013 Impact Assessment Survey	50% of TBAs/TTBAs who can Identify at least 3 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines			

		e-45% -2010)					
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 (w/m)	Mid year and annual reports	4,000 people using family planning methods (w/m)			
	Provide family planning education	No. of people using family planning methods (Baseline-22.9%)	2013 Impact Assessment Survey	8% of 44,941 people of reproductive age			
	Conduct TTBA training	No. of new TTBAs complete the training		18 TTBA training for 360 people (w/m)			
	Conduct TBA/TTBA workshops	No. of TBA/TTBA Follow-up Workshops held & no. of TTBAs attending (w/m)		160 follow-up TBA/TTBA Workshops for 800 TBAs/TTBAs (w/m)			
	Provide safe birthing kits	No. of births attended by trained TBAs/TTBAs and health workers, among total target population % of births attended by trained	TBA's/TTBA's form; mid year & annual report	- 4,000 babies delivered by trained TBAs/TTBAs and health workers - 60% of births will be attended by TBAs/TTBAs 35% of birth will be			

		TBAs/TTBAS % of births attended by health workers (Baseline – TBA - 67%, health worker – 27%)	Impact Assessment survey	attended by health workers			
		No. of TBA/TTBA kits provided	Kits distributing list; midyear & annual report	1,900 TBAs/TTBAs kits			
		No. of maternity kits provided		7,600 maternity kits			
		Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010, povidine/Iodine or other antiseptic = 354 (85%) -2010	TBA assessment survey	- 80% of new razor blade, sterile scissors, and etc were used - 88% of povidine/Iodine or other antiseptic were used			
		At the last pregnancy that you delivered provide at least 3 information = 353 (85%) -2010	TBA Assessment Survey	- 88% of postpartum women were given at least 3 information			
4. Provide	Document	No. of newborn baby received	Delivery record	2,200 delivery			

delivery records	deliveries	delivery records	issued copies, midyear and annual report	records			
5. Converge and coordinate with the Burma government's state administered Reproductive healthcare program in Karen State.	Organize Auxiliary Midwife Training	No. of AMW training provided	AMW training report & attendance list	2 Auxiliary midwife training will be provided			
		No. of AMWs participate in the training		20 AMWs will participate in each AMW training			
Capacity Building							
1. Improve health worker and staff knowledge and skills	CHW ToT training	No. of CHW attend the ToT training (w/m)	CHW ToT training report & attendance list	1 CHW ToT for 20 CHW			
	VHW ToT training	No. of health workers attend ToT training (w/m)	VHW ToT training report & attendance list	1 VHW ToT for 20 health workers			
	MCH/TTBA ToT training	No. of MCH supervisors attend the ToT training	MCH ToT training report &	1 MCH ToT for 20 MCH supervisors			

		(w/m)	attendance list				
	CHW training	No. of trainees completed CHW training (w/m)	CHW training report & attendance list	4 CHW trainings for 120 CHW (w/m)			
	MCH refresher training course	No. of trainees complete medical refresher course training (w/m)	MCH training report & attendance list	1 MCH refresher training course for 30 MCH			
	Medical Refresher training course	No. of trainees complete medical refresher course training (w/m)	Medic refresher training report & attendance list	1 refresher course training for 30 medics (w/m)			
	Attend international conferences and meeting	No. of times and participants in international conferences & meeting	Mid year & annual report	Attend 2 international conference or meetings attended by 2 staff members			
	Attend local conferences and meeting	No. of times and participants in local conferences & meeting	Mid year & annual report	6 local conferences or meeting will be attended by 8 staff members			
	Attend international and local short course	No. of participants attend short	Mid year & annual	4 staff members will attend short course			

	training	course training	report	training			
	Organize organization development training	No. of participants attend OD training	Attendance list	15 staff members will attend OD training			
	Organize project management training	No. of participants attend project management training		15 staff members will attend project management training			
	Organize internship program	No. of participants	Attendance list	60 staff members will attend internship program			
2. Promote gender equality in leading positions	Review adopting polies	% of women leading health programs	Field report & staff list	At least 30% of women leading health programs			
		% of women field in-charges	Field report & staff list	At least 30% of women field-in charge			
		% of women in leading committee	Annual report & staff list	At least 30% of women in leading committee			
	Hold the BPHWT general selection triennially	% of women was elected	Annual report & staff list	At least 30% of women in leading committee			
Health Information and Documentation							
1. Assess and document	Produce HID materials	No. of calendars produced	HID staff report	1,000 calendars provided			

community health situation and needs		No. of digital cameras and no. of video cameras provided		20 digital cameras and 2 video cameras will be provided			
2. Standardize health data collection processes	Analyze data collected by health workers	Frequency of analysis	Six months workshop report	Twice a year			
		No. of participants		10 participants each time.			
3. Make evidenced based health status comparisons with the target community	Organize field meetings and workshops	No. of field meetings or workshops provided	Field meeting and workshop report	Twice a year for 20 areas			
		No. of participants		200 people participate in field workshop and 200 in meeting			
4. Raise awareness of the community health problem	Produce health information, education and communication materials	No. of health information and communication (IEC) materials provided	IEC distributing list; village health workshop report form	No. of posters provided			
5. Advocate local and international organizations about the health situation in Burma	Organize health program coordination and development seminars	No. of seminar	Annual report	At least once a year			
		No. of participants	Annual report	30 people will participate in the seminar			

Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	Conduct impact assessment survey	Frequency of impact assessment survey conducted	Midyear & annual report	Once every two year			
	Conduct monitoring trip	No. monitoring trips and no of staff		3 monitoring trips in a year			
	Conduct six months meeting	No. of health workers attend the six months meeting		120 health workers attend the six months meeting			
	Provide Leading Committee meetings	No. of Leading Committee meetings provided	Office records	2 Leading Committee meetings per year			
	Provide Executive Board meetings once in a month	No. of Executive Board meetings provided		12 Executive Board meetings per year			
	Provide staff meetings	No. of staff meetings provided		24 staff-meetings per year			
Health Convergence							
1. Converge the extensive border-based health system with the Burma	Standardize curriculum between border-based health CBOs and Burma	No. of seminars and meetings No. of participants	Attendance list	Twice in a year			

government's health system	government						
	Health program convergence between border-based health CBOs and the Burma government	No. of seminars and meetings No. of participants No. of field visits	Attendance list	Twice in a year			
	Health system convergence between the border-based health system and Burma government	No. of seminar and meetings No. of participants	Attendance list	Twice in a year			
	Health program coordination and development seminar	No. of seminar and meetings No. of participants	Attendance list	Once in a year			
	Organize Auxiliary Midwife Training	No. of AMW training provided No. of AMWs participate in the training	AMW training report & attendance list	2 Auxiliary midwife training will be provided 20 AMWs will participate in each AMW training			

IX. 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. Increase more BP teams			✓	✓				✓	✓			
2. Provide medicine and medical supplies			✓	✓				✓	✓			
3. Treat common diseases and minor injuries	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Provide ITNs			✓	✓					✓	✓		
5. Provide malaria rapid tests			✓	✓					✓	✓		
6. Provide ACT to patients with malaria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7. Collect caseload information, population information	✓						✓					
8. Purchase emergency medical supplies	**As necessary**											
9. Field Meetings	✓						✓					
10. Field workshops			✓						✓			
11. 6 monthly meetings/workshops		✓						✓				
12.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. Provide school health education						✓					✓	
3. Village Health Workshops				✓	✓					✓	✓	
4. Health campaign				✓	✓					✓	✓	
5. Village health worker training				✓	✓	✓				✓	✓	✓
6. Distributing VHW kits				✓						✓		
7. VHW 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. Distribute Vitamin -A and Albandazole			√	√					√	√		
2. Distribute Iron			√	√	√	√			√	√	√	√
3. Referral of serious obstetric cases	√	√	√	√	√	√	√	√	√	√	√	√
4. Provide ANC	√	√	√	√	√	√	√	√	√	√	√	√
5. Provide obstetrics gynecology instruments		√						√				
6. Provide family planning supplies			√	√	√	√			√	√	√	√
7. Provide family planning education				√	√	√	√				√	√
8. Conduct TTBA training			√	√					√	√		
9. Conduct TBA/TTBA workshop			√	√					√	√		
10. Provide TBA / TTBA Kits and Maternity Kits			√	√					√	√		
11. Document and issue delivery records	√	√	√	√	√	√	√	√	√	√	√	√
12. Organize auxiliary midwife training	√	√	√	√					√	√	√	√
Capacity Building												
1. Organize CHW ToT		√										
2. Organize MCH/TTBA ToT		√										
3. Organize VHW ToT			√									
4. Organize community health worker training				√	√	√	√	√	√	√	√	√
5. Organize MCH Refresher Training Courses				√	√	√						
6. Organize medical Refresher Course									√	√	√	√
7. Attend local and international conferences and trainings					√	√			√	√		
8. Attend local and international short course training					√	√			√	√		
9. Organize organizational development training		√	√				√	√				
10. Organize project management training				√	√					√	√	

11. Organize internship program	√	√	√	√	√	√						
12. Review adopting polies								√				
13. Organize the sixth conference								√				
Health Information and Documentation												
1. Provide HID materials	√	√				√	√					
2. Analyze data collected by health workers	√	√				√	√					
3. Provide health information and communication materials	√	√				√	√					
4. Organize health program coordination and development seminars	√	√				√	√					
Program Management and Evaluation												
1. Conduct impact assessment survey						√						
2. Conduct monitoring trips			√	√					√	√		
3. Conduct six monthly meetings		√						√				
4. Organize Leading Committee meetings	√						√					
5. Organize Executive Board meetings	√	√	√	√	√	√	√	√	√	√	√	√
6. Organize staff meetings	√	√	√	√	√	√	√	√	√	√	√	√
Health Convergence												
1. Standardize curriculum		√										
2. Health program convergence		√										
3. Health system convergence		√										
4. Organize health program coordination and development seminars		√										

X. Budgeting (January to December 2013)

Items	Jan-Jun 2013	Jul-Dec 2013	Total	% by program	% total budget
I. Medical Care Program (MCP)					
A) MCP 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 (22,000B x100 BPs)	2,200,000	2,200,000	4,400,000	34%	
2. Malaria Medicine & supplies (12,000B x 100 BPs)	1,200,000	1,200,000	2,400,000	19%	
3. Malaria rapid test (40 B x 150 x100BPs)	600,000	600,000	1,200,000	9%	
4. Mosquito net - ITN(150 B x 3,500 + 3,500)	525,000	525,000	1,050,000	8%	
5. Medicine transportation (3,000 B x 100 BPs)	300,000	300,000	600,000	5%	
6. MCP worker's operation cost (1,200 B x 6 mths x 100 persons)	720,000	720,000	1,440,000	11%	
7. Field-coordinator operation cost (1500 B x 6 mths x 20 persons)	180,000	180,000	360,000	3%	
8. Emergency medical supplies	200,000	200,000	400,000	3%	
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 & supplies for Health center (15,000 B x 8centers)	120,000	120,000	240,000	2%	
13. Malaria rapid diagnostic test for Health center (40B x 150 x 8 centers)	48,000	48,000	96,000	1%	
14. Food and stipend for Basic Health Clinic staff (10 staffsx1500Bx6+6mths)	90,000	90,000	180,000	1%	
15. Medicine and supplies for Basic Health Clinic (60,000 B x 1+1 term)	60,000	60,000	120,000	1%	
MCP Activities and supplies cost sub total	**6,343,000**	**6,268,000**	**12,611,000**	**99%**	
MCP Sub Total	**6,418,000**	**6,343,000**	**12,761,000**	**100%**	**28 %**
II. Community Health Education and Prevention Program (CHEPP)					
A) Program Operation Cost					
1. Program coordinator operation cost (8,000 B x 6 mths x 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	0%	
3. CHEPP Workers operation cost (1,200 B x 6 mths x 100 persons)	720,000	720,000	1,440,000	12%	
4. Field coordinator operation cost (1,500 B x 6 moths x 20 fields)	180,000	180,000	360,000	3%	
Program operation cost sub total	***1,023,000***	***1,023,000***	***2,046,000***	**17%**	
B) 1. Village Health Worker Training/Workshop					
1. Village Health Worker Training (100,000B x 10+10 training)	1,000,000	1,000,000	2,000,000	16%	
2. Village Health Worker Workshop (1,500B x 60+100 workshop)	90,000	150,000	240,000	2%	
3. Village Health Worker handbooks (150B x 200 + 200 books)	30,000	30,000	60,000	0%	
4. Village Health Worker Kits (21,000B x 60+100 kits)	1,260,000	2,100,000	3,360,000	27%	
5. VHW stipend (5000 B x 100 teams)	200,000		200,000	2%	
VHW Training/workshop sub total	***2,580,000***	***3,280,000***	***5,860,000***	**18%**	
C) School Health Promotion		**430,000**	**430,000**	**3%**	
D) Village Health Workshop (3,000 B x 95 workshop)	**285,000**	**285,000**	***570,000***	**5%**	
E) Water & Sanitation					
1. Gravity flow water system (40,000 B x (10+10)	400,000	400,000	800,000	6%	

2. Shallow well water system (5,000 B x (30 +30)	150,000	150,000	300,000	2%	
3. Community Latrine (500B x 1500 + 1500)	750,000	750,000	1,500,000	12%	
Water & Sanitation sub total	***1,300,000***	***1,300,000***	***2,600,000***	**21%**	
F) Nutrition Promotion					
1. Vitamin A distribution (3 B x 42,000 + 42,000)	126,000	126,000	252,000	2%	
2.De-worming for mebendazole (1.5 B x 40,000 + 40,000)	60,000	60,000	120,000	1%	
Nutrition promotion sub total	**186,000**	**186,000**	***372,000***	**3%**	
G)Communicable Disease Control (Lymphatic Filariasis Pilot Program)					
1. DEC (48,500 tabs + 30,000 tabs)x 2.4B	116,400	72,000	188,400	2%	
2. Albendazole (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 (1,500 B x 6 mths x 5 staffs)	45,000	45,000	90,000	1%	
Communicable Disease Control (LF Pilot Program) sub total	**227,400**	**137,000**	**364,400**	**3%**	
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	***5,701,400***	***6,641,000***	***12,342,400***	***100%***	**27 %**
III. Maternal and Child Health Program (MCHP)					
A) Program Operation Cost					
1. Program coordinator operation cost (8,000 B x 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 100 persons)	720,000	720,000	1,440,000	21%	
4. Field coordinator operation cost (1,500B x 6 mths x 20 person)	171,000	171,000	342,000	5%	
5. TTBA Curriculum (hand book) 500 x 70 B	35,000	0	35,000	1%	
MCHP program operation cost sub total	***1,049,000***	***1,014,000***	**2,063,000**	**30%**	
B) TTBA Training (40,000B x 9 + 9 training)	***360,000***	***360,000***	***720,000***	**10%**	
1. TTBA Kit (400 B x 20 TBAs x 9 + 9 training)	*72,000*	*72,000*	*144,000*	2%	
TTBA Training	***72,000***	***72,000***	***144,000***	**2%**	
C) TBA / TTBA Workshop (9000 B x 80 + 80 sessions)	**720,000**	**720,000**	**1,440,000**	**21%**	
1. TBA Kit (400 B x 10 TBAs x 80+80 sessions)	320,000	320,000	640,000	9%	
2. Maternity Kit (150 B x 4 mothers x 10 TBAs x 80+80 sessions)	480,000	480,000	960,000	14%	
MCHP Follow-up workshop sub total	***800,000***	***800,000***	***1,600,000***	**23%**	
D) Obstetrics Gynecologic (OG) Instruments (5000B x 60 sets)	***0***	***300,000***	***300,000***	**4%**	
			0	0%	
E) Delivery record	***30,000***	***0***	***30,000***	**0%**	
F)Family Planning				0%	
1.Family Planning Supplies	*200,000*	*200,000*	*400,000*	6%	
2.Family Planning Education (1,000B x 95 BP x 1+1 term)	*95,000*	*95,000*	*190,000*	3%	
Family Planning sub total	***295,000***	***295,000***	***590,000***	**9%**	
MCHP Sub Total	***3,326,000***	***3,561,000***	***6,887,000***	***100%***	**15%**
IV. Capacity Building Program (CBP)					
A. Capacity Building					
1. CHW training (350,000 B x 4 training)	1,400,000		1,400,000	32%	
2. Refresher Training Course-30 medics (350,000 x 1 + 1 Terms)	350,000	350,000	700,000	16%	
3. International Conference and Training	250,000	250,000	500,000	12%	
4. VHW TOT Training 1 course	150,000		150,000	3%	
5. Training monitoring & evaluation	50,000		50,000	1%	

6. TOT For TTBA/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	10%	
9.Organisation 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	50,000	50,000	100,000	2%	
12.Local and international health institution (60,000B x 4 persons x 1 time)	240,000		240,000	6%	
13.Internship Program (8,000B x 30+30 persons)	240,000	240,000	480,000	11%	
Capacity Building Sub total	**3,104,000**	**1,234,000**	**4,338,000**	**100%**	
Capacity Building Program sub total	***3,104,000***	***1,234,000***	***4,338,000***	***100%***	**9.5%**
V. Health Information and Documentation (HID)					
A. Health Information & Documentation					
1. Program coordinator operation cost (8,000 B x 6 mths x 1person)	48,000	48,000	96,000	13%	
2. Program staff operation cost (4,500B x1 person x 6mths)	27,000	27,000	54,000	8%	
2. Still digital camera (6,000 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	8%	
5. Memory stick and video tape	25,000	25,000	50,000	7%	
6. Publication (Calendar)	0	70,000	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. Publications (Poster)		50,000	50,000	7%	
Health Information and Documentation Sub total	**325,000**	**395,000**	**720,000**	**100%**	
HID Sub total	***325,000***	***395,000***	***720,000***	***100%***	**1.6%**
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	11%	
2. Director stipend (8,000 B x 1 person x 6 mths)	48,000	48,000	96,000	2%	
3. Deputy director stipend (8,000 B x 1 person x 6 mths)	48,000	48,000	96,000	2%	
4. Treasurer stipend (8000 B x 1person x 6 mths)	48,000	48,000	96,000	2%	
5. Finance manager stipend (8,000 B x 1 person x 6 mths)	48,000	48,000	96,000	2%	
6. Accountant stipend (6,500 B x 1 person x 6 mths)	39,000	39,000	78,000	2%	
Program managing cost sub total	***471,000***	***471,000***	***942,000***	**22%**	
B. Six monthly meeting and 3 main programs workshop	**1,020,000**	**1,020,000**	**2,040,000**	47%	
C) Field Meeting and Workshop				0%	
a. Field Meeting	**230,000**	**230,000**	**460,000**	11%	
b. Field Workshop	**180,000**	**180,000**	**360,000**	8%	
D) Program Monitoring and Evaluation					
1. Monitoring trip (30,000 B x 3 trips)	90,000		90,000	2%	
Program monitoring and evaluation sub total	***90,000***	***0***	***90,000***	**2%**	
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 12+12 times)	6,000	6,000	12,000	0%	
Management Meeting sub total	***17,000***	***17,000***	***34,000***	**1%**	
F) Health Convergence Activities					
a. Health Convergence Meeting	***30,000***	***0***	***30,000***	**1%**	

b. Health Program Coordination and Development Seminar		***160,000***	**160,000**		
G) Impact Assessment Survey Training	**250,000**	**0**	**250,000**	**6%**	
Program Management and Evaluation sub total	**2,288,000**	**2,078,000**	**4,366,000**	***100%***	**9.6%**
VII. General Administration					
A. Office running cost					
1. Office running cost (65,000 B x 6mths)	**390,000**	**390,000**	**780,000**	**19%**	
B. Office supplies					
1. Office furniture	20,000	20,000	40,000	1%	
2. Computer maintenance	10,000	10,000	20,000	0%	
3. Money Transfer Fees	20,000	20,000	40,000	1%	
4. Car warranty and maintenance	70,000	50,000	120,000	3%	
5. Cabinet 3,000 B x 20 sets)	30,000	0	30,000	1%	
6. Food for staff members (36,000 B x 6 + 6 mths)	216,000	216,000	432,000	11%	
Office supplies total	**366,000**	**316,000**	**682,000**	**17%**	
C. staff stipend					
1. Office staff' stipend (4,500 B x 5 persons x 6 mths)	135,000	135,000	270,000	7%	
2. Office manager stipend (8,000 x 1person x 6 mths)	48,000	48,000	96,000	2%	
3. Driver stipend (4,000B x 3persons x 6mths)	72,000	72,000	144,000	4%	
4. Social support	100,000	100,000	200,000	5%	
5. Registration (6,000 B x 15 Persons)	90,000	0	90,000	2%	
6. Intern stipend (2,000 B x 10 persons x 6month)	120,000	120,000	240,000	6%	
7. Cook fee (3,000Baht x 4 persons x 12 month)	72,000	72,000	144,000	4%	
staff stipend total	**637,000**	**547,000**	**1,184,000**	**29%**	
D. Other Administration					
1. Auditor fee	50,000	0	50,000	1%	
2. Air Ticket Fees (20,000 B x 2 persons x 1+1 time)	40,000	40,000	80,000	2%	
3. Domestic traveling cost (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 meeting	50,000	50,000	100,000	2%	
6. Computer (Desktop/Laptop) 3 Sets (25,000 B x 3 Sets)	75,000	0	75,000	2%	
7. Meeting hall Renovation	100,000	0	100,000	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	4%	
10. Emergency Health care	100,000	100,000	200,000	5%	
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	1%	
13. Car	300,000		300,000	7%	
14. Communication center (6,000B x 1+1 term)	60,000	60,000	120,000	3%	
Other administration cost total	**983,000**	**426,000**	**1,409,000**	**35%**	
Total Administration	***2,376,000***	***1,679,000***	**4,055,000**	***100%***	**8.9%**
Grand total for all programs in 2013	**23,538,400**	**21,931,000**	**45,469,400**	**100%**	**100%**