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

2015 Proposal
Back Pack Health Worker Team

2015 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, Chin and Arakan areas
Project Duration:	January to December 2015
Budget requested:	**40,000,000** Thai Baht **(1,333,332 USD)**
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I. Overview

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

The armed conflicts in Burma date back to the time of its independence in 1948 and have been virtually continuous since then through various Burma governments, both civilian and military. The key issues are related to the non-Burman peoples and their social, economic, and political aspirations. During the British colonial period, the non-Burman ethnic peoples were generally administered separately and differently by the British than those in the predominately Burman area, i.e., Ministerial Burma. As the inducement to become part of a post-independence Burma, certain non-Burman ethnic peoples were promised local autonomy and ethnic quality. They were also offer the right of secession from Burma, if after ten years, they felt that their aspirations were not realized within Burma.

During the ensuing 14 years, the non-Burman people were unable to receive either local autonomy or ethnic equality, and thus in 1962, commenced a meeting to speak to this issue and the alternatives available to them. Immediately, the Burma Army, under Ne Win, mounted a coup under the rationale that the country was on the verge of breaking apart based along ethnic lines and the then-civilian government was not effectively addressing the ethnic issue. As a result over the next fifty years, many non-Burman ethnic people formed political/armed groups to initially fight for independence and later for local autonomy as manifested in some equitable form of political power sharing with the devolution of significant executive, legislative, and judicial authority to the constituent ethnic and multi-ethnic states; equitable representation at the Union level in both houses of parliament, government ministries, and the military; and a fair sharing of state resource revenues. Thus, successive Burma military and Burma military-supported civilian governments have held political power since 1962 in an attempt to address the ethnic issue primarily through military means, feeling that democratic civilian governments lack the capabilities to prevent a “disintegration of the Union”.

There were a number of ceasefire agreements concluded with ethnic armed resistance organizations (EAROs) during the 1990s; however, there were no efforts by the military government to address the underlying political issues. In 2009, the Burma Government gave the ceasefire groups the choice of converting to a border guard/peoples militia force under the control of the Burma military or giving up their weapons and “returning to the legal fold”. If they chose neither, then the ceasefire agreements with the government would be voided and the former ceasefire groups would be then considered by the Burma Government as belligerents. While some ceasefire groups did convert to border guard/people militia forces, others were attacked by the Burma military and have continued to fight a defensive war against them up through the present time.

The new civilian Burma Government, elected in 2010, has seen the ethnic situation as a military stalemate and hampering its transition to more democratic country. Thus, it has initiated a series of negotiations with many EAROs, resulting in a series of individual temporary ceasefire agreements to try to begin a process of national reconciliation with the

ethnic people. These ceasefire talks between the EAROs and the Burma Government have made some progress toward a more permanent Nationwide Ceasefire Agreement (NCA). But, there is still no explicit agreement by the Burma Government upon the key demand of the EAROs for a federal union. The EAROs want a federal union for Burma to a part of the NCA while the Burma Government would only agree that it should be a topic for discussion at a political dialogue to be held after the signing of the NCA.

In many of the areas of the country covered by the temporary ceasefire agreements, the Burma military has engaged in offensive military operations which are violations of these agreements. Thus, the Burma military may not perceive the situation in the same manner as the Burma Government and may try to continue to use force to try to bring about a military solution to the ethnic issue. Continued offensive operations by the Burma military has increased the number of internally displaced persons (IDPS) in Shan and Kachin States, discouraged refugees from considering returning to Burma, and not contributed to confidence building among the EAROs. If the Burma military does not cease their offensive military operations and expanding their reach, manpower, and armaments in the ceasefire areas, the ceasefire EAROs may resort again to fighting to protect their people and to force the Burma Government and military into genuine peace negotiations.

Therefore to address this issue, the EAROs want a Military Code of Conduct to be incorporated into the NCA or signed separately at the same time as the NCA. The Burma Government wants any Military Code of Conduct discussions held after the signing of the NCA. A Military Code of Conduct would address the dispositions, demarcations, areas of operations, armaments, monitoring, and other aspects designed to protect the terms of the NCA during the political dialogue up through the creation and implementation of a National Accord and subsequent integration of the EAROs into state/region militias or reintegration into civilian pursuits.

Additionally, the Burma Government has been extending its reach through economic development and humanitarian assistance in the mixed- and EARO-controlled areas, enhancing infrastructure (especially roads and bridges), tourism, and granting of access to international non-governmental organizations (INGOs). The end result is intended, according to some observers, to undermine the power of the EAROs to use force should ceasefire agreements break down, supply the Burma military with good transportation routes and strengthened their military capabilities for any possible dry season military offensives, and provide substitute health, education, and livelihood opportunities directly and through INGOs to ethnic people to weaken the relationships between the ethnic people and the administrative agencies of the EAROs. The ethnic people have made it clear, through their political leaders, that peace and security must come first before humanitarian assistance and economic development in the ethnic areas.

It is hoped that 2015 will be year not only for free, fair, and transparent elections with a move toward a true democracy, but also a year that sees a genuine road to durable peace in Burma through productive and genuine negotiations between the Burma Government/

military and the EAROs about equitable power sharing – political, military, territory, and resource - and ethnic equality.

(ii) The General Health Situation in Burma

Health in Burma is another casualty of decades of military misrule, ethnic conflict, centralized decision making, and the exodus of qualified health professionals. Thus, there has been, and continues to be, a shortage of qualified physicians, nurses, midwives, and community health workers as well as inadequate medicine, medical equipment, and hospital/clinic beds. Hospital facilities are run down and require renovation. The reliability of electricity in health facilities is a constant problem. Also, people living in armed conflict and remote areas have no reasonable access to health care within a few days' walk. Many rural and urban areas lack clean water and proper sanitation. There is no real Burma Government healthcare scheme and patients must pay for medicine, food, blankets, and bribes to medical personnel.

Providing Healthcare in Papun field area

The World Health Organization, in its April 2012 Fact Sheet N#319 entitled *Spending on health: A global overview,* notes that Myanmar is the country with lowest government spending per person per year on health. Consequently, the country has some of the worst health indicators in the world. 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.

For the 2013-14 fiscal year, the Burma government allocated 3.8 percent of the national budget for health care. This was an increase from the 1.3 percent for the 2011-12 fiscal year. However, questions have arisen as to how much of this spending actually occurred and what has been the impact upon the health infrastructure and health indicators from any spending. Also much of this spending has been in the urban, not rural, areas where most of the ethnic people live.

Lastly, the health system in Burma mirrors that of the government, that is, unitary and centralized. Decision making and funding comes from the center or "top down". Whereas the health systems of the ethnic health organizations tend toward community-based decision making or "bottom up". This will be an issue as the health structure of Burma evolves with positive progress toward a durable peace.

(iii) The Health of Internally Displaced Persons (IDPs)

The Internal Displacement Monitoring Centre estimates that up to 400,000 people may be internally displaced in southeastern Burma and up to another 100,000 IDPs in Kachin State and Northern Shan State. Armed conflict, human rights abuses, and development-induced displacement continue to be the key underlying factors for these large numbers of IDPs.

While the health indicators of Burma's population rank amongst the poorest globally, the health of IDPs within Burma is even a more serious cause for concern. Health indicators for the rural ethnic and IDP populations in eastern areas of the country 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 the healthcare system of the Burma Government is either extremely limited or non-existent.

These remote and conflict-affected regions of Eastern Burma continue to face critical health challenges and are characterized by high morbidity and mortality rates. This is especially true in respect to the high mortality rates for infants and among children under 5 years of age, and deaths across all age groups attributable to largely preventable diseases such as diarrhea, malaria, and acute respiratory infections.

Consequently, there will be the continuing need for primary health care by the IDPs and other vulnerable people in Eastern Burma which can only be currently met through the ethnic health organizations, not through the Burma Government. Humanitarian organizations must recognize that that the situation in the conflict areas is in the initial stage of peacemaking – there are only temporary, not permanent, ceasefire agreements in place. With the signing and successful implementation of a Nationwide Ceasefire Agreement, movement would be from peacemaking to peacekeeping, and only then hopefully to true peace building. It will be only after a political dialogue that results in a National Peace Accord incorporated into a federal union constitution that the EAROs will be ready to disarm, demobilize, and reintegrate back into a democratic Federal Union of Burma/Myanmar. Until then, the EAROs will retain their arms and administrative control over and access to their respective ethnic areas. Thus, the effective delivery of healthcare services to people living in the EARO-controlled areas, especially IDPs, will be through ethnic health organizations

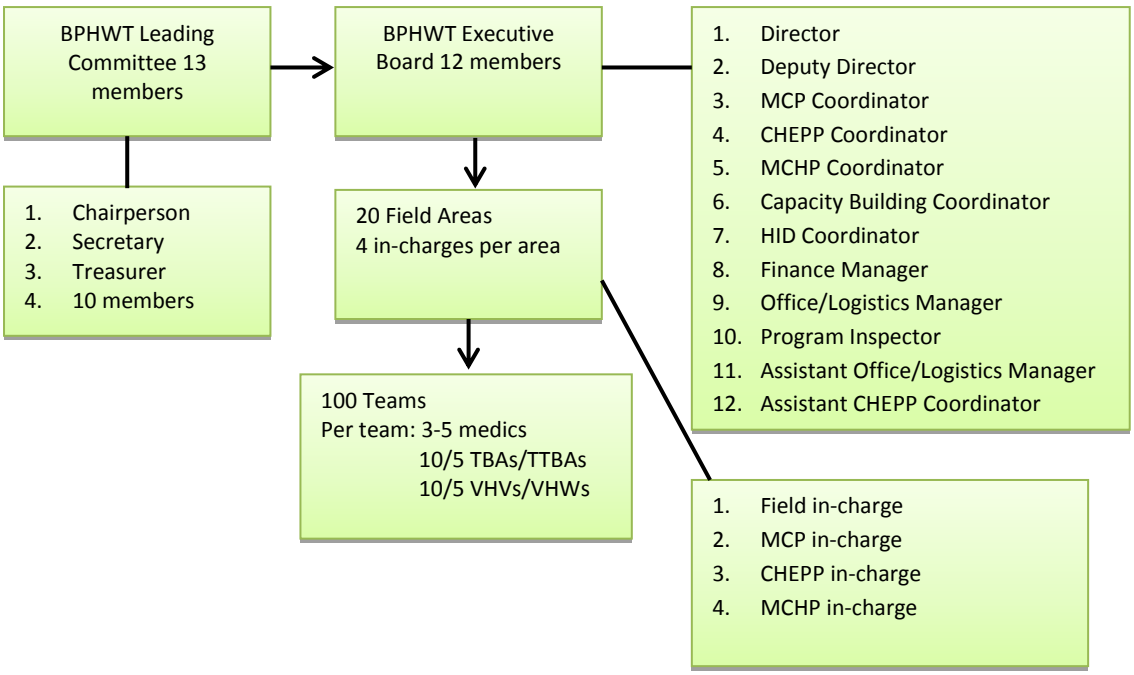
Ethnic people, including IDPs, living in the EARO-controlled areas have a right to health. Humanitarian organizations who have reallocated funding away from the ethnic health organizations may be considered as denying these people of their right to health to which they formerly enjoyed, since previously-funded ethnic health organizations may need to reduce their services or size of served populations due to any loss of funding. This could result in "Doing Harm" to the IDPs and other vulnerable people, and violating the spirit, if not the intent, of international declarations and covenants of people's rights to health. Thus, decisions to reallocate funding away from ethnic health organizations must consider the

impact upon those people currently receiving health care and their right to health, especially to basic primary health care.

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. During the first six-month term of 2014, the BPHWT continued to provide health care in 20 field areas with 100 teams assigned to a target population of over 211,010. There are currently over 1,292 health workers living and working in the BPHWT target area in side Burma, connected with the BPHWT consisting of 354 medics – 179 men and 175 women, 711 Traditional Birth Attendants/Trained Traditional Birth Attendants (TBAs/TTBAs) – 63 men and 648 and 227 village health volunteers/Village Health Workers (VHVs/VHWs).

(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 targeting the various ethnic nationalities and communities in Burma to be happy and healthy society.

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 mid-year of 2014, fifty-six percent of the BPHWT staff was women, excluding Traditional Birth Attendants (TBAs). However, the organization has a gender policy, which aims to improve equity for women across all levels of the organization. The table below depicts the current targets and actual percentage of women across organizational tiers. To date, the BPHWT meets or exceeds all gender equity targets for organizational tiers, except for the target set for Office Staff.

Gender Analysis of the People Working within the BPHWT

Category	Total # of Workers	Total # of Women	Actual Women %	Women Target at Least %
Leading Committee/Executive Board	15	6	40%	**30%**
Office Staff	12	3	25%	**30%**
Field Management Workers	69	29	42%	**30%**
Field Health Workers	285	146	51%	**30%**
Traditional Birth Attendants/Trained Traditional Birth Attendants	711	648	91%	**Target not set**
Village Health Volunteers/Village Health Workers	227	157	69%	**30%**
Organizational Total	**1,319**	**989**	75%	**Target not set**
Total Organization excluding TBAs/TTBAs			**56%**	**30%**

III. Back Pack Health Worker Team 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 targeted field 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 16 years, the most common diseases treated by the BPHWT have been malaria, acute respiratory infections (ARI), worm infestation, anemia and diarrhea. During January to June 2014, the BPHWT treated about 42,767 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 field 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:

- Maintaining the existing 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. The BPHWT has been using RDT kits SD of Bio-line to check for both Plasmodium vivax (Pv) and (Pf) malaria since the second six month period of 2013.

- 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. Since 2013, the BPHWT has started using Coartem for malaria treatment.

- 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. 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, 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.

Providing Vitamin A and De-worming in schools

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

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

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.

Building latrines in communities

- 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/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.

(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 communities 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).

Organizing TTBA training in the field areas

In the Maternal and Child Healthcare Program, capacity building is delivered through the six-monthly Maternal and Child Healthcare refresher training course 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.

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
- 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.

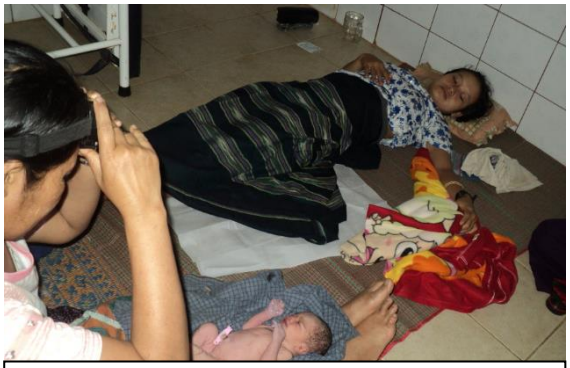
- Since TBAs are being phased out, only TTBA trainings will be conducted, but TBA workshops will continue until all TBAs have been upgraded to TTBAs. In rural Burma, TBAs/TTBAs are usually the first ones who help pregnant women and their families with the delivery of their babies. In many areas where 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.

- 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.



A TBA is delivering a baby

- 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 2014). 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.

4th Auxiliary Midwife Training in Pa An

- AMW training will be four months long, followed by a three month practical which will take place in Mae Tao clinic. 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. The kits will be provided for them.

(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, MCH refresher, Medical refresher, Public Health, and Technical refresher training (Malaria & EPI)
- 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:

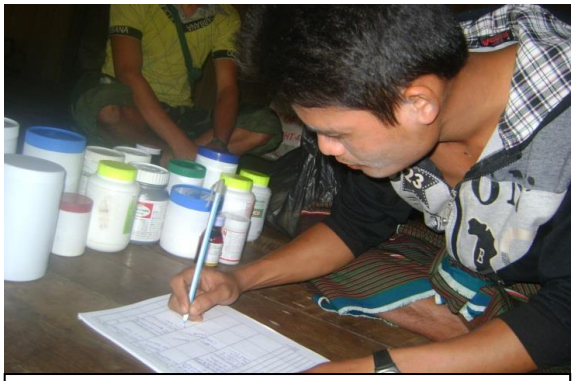
- Conduct community needs assessment and impact assessment
- Provide HID materials
- Analyze data collected by BP health workers
- Organize field training and/or workshops aimed at standardizing case-definition data collections
- Produce health information, education, and communication materials for 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.



Collecting caseloads information /data

- 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

Over the past decade, the Burma Government has spent only around 1% of its national budget annually on health care and as a consequence, the healthcare system is rather inadequate, particularly in the rural areas. In contrast over the past twenty-five years, international aid agencies and donors have invested heavily and successfully in building the capacity and network of the border-based health system through technical support and funding focusing on service delivery, program development and management, policies and procedures, reporting, medical and public health training, surveys, assessments, research, monitoring, evaluation, and other such capacity building. This investment of technical expertise and funding have resulted in an efficient and effective ethnic primary healthcare system which has been successful in

5th Health Convergence Core Group Meeting

addressing the healthcare needs of the ethnic people, despite situations of ongoing conflict and difficult working conditions. Also this system is community-based and has been providing the necessary knowledge, experience, and skill sets to local people for them to become more responsible for their own health care.

Spurred by the ongoing peace process in many ethnic areas of Burma, the BPHWT and other ethnic health organizations (EHOs)/health community-based organizations (HCBOs) have been working to converge this extensive border-based health system with the other ethnic health systems inside Burma and the Burma Government's health system to provide better health care, access more of the population, improve health system and policy, and gain Burma Government recognition of border-based health organizations, programs, and workers. This is a slow process as convergence needs to occur at the system, policy, structural, and program levels, and be aligned with progress in the ongoing ceasefire and peace negotiations between the Burma Government and the ethnic political and armed resistance organizations.

This collaborative initiative began in May 2012 with the establishment of the Health Convergence Core Group (HCCG). The aim of the HCCG is to prepare existing ethnic community-based health networks, both inside Burma and those managed from the Burma border areas, for future possibilities to work together with Union and state/region government health agencies, ethnic authorities, international donors, international non-governmental organizations (INGOs), and civil society organizations. The purpose of the HCCG is to explore policy options for achieving the convergence of ethnic health networks with the health system of the Burma Government through political dialogue. At the end of June 2014, the HCCG consisted of nine EHOs/HCBOs:

- Backpack Health Worker Team (BPHWT)
- Burma Medical Association (BMA)
- Chin Public Affairs Committee (CPAC)
- Karen Department of Health and Welfare (KDHW)
- Karenni Mobile Health Committee (KnMHC)
- Mae Tao Clinic (MTC)
- Mon National Health Committee (MNHC)
- National Health and Education Committee (NHEC)
- Shan State Development Foundation (SSDF)

In looking at both the health system of the Burma Government and that of the Burma border-based managed EHOs, it is seen that the Burma Government health system is highly centralized while those of the border-based managed EHOs are decentralized. Within this context, the HCCG has been looking at various global health system models:

- Centralized/deconcentrated health systems – The government is responsible for the health care of the people - curative, promotive, preventative, and rehabilitative.

- Devolved health systems – The government and the people are both responsible, to varying degrees depending on structure, for the health care of the people – curative, promotive, preventative, and rehabilitative.

From these health system studies, devolved health systems, especially primary health care, seem most compatible with the situation in Burma as they are more community-based, more responsive, and more in line with the aspirations of the ethnic people. Also devolved health systems appear to be the accepted global model.

The BPHWT has been moving forward with convergence activities at the program level; convergence at the policy, system and structural level will develop in conjunction with the ceasefire/peace process and as a durable, meaningful political change occurs in Burma. These ongoing initiatives with both Union and state/region health officials in Burma include:

- Expanding immunization programs
- Addressing the emergence of drug-resistant malaria
- Expanding the reproductive and child health workforce
- Information sharing on health indicators
- Health worker recognition and accreditation
- Procurement strategies
- Overlaps and gaps in programs, protocols, and target areas
- Pilot convergence activities (e.g., Auxiliary Midwife Program)
- Mutual recognition of health infrastructures
- Meetings and workshops
- Concept of health convergence

Also the BPHWT has hosted and participated in a number of HCCG activities:

HCCG Policy Meetings
Exploring policy options for a federal decentralized health system

Health System Development Seminars
Health as a Bridge for Peace
Health equity during political transformation period
Health Policy Option paper
Development of the health system and policy for future Burma/Myanmar

Health Convergence Presentations in Kachin and Karenni States

Health Services Mapping

Myanmar Peace Support Group (MPSI) Meeting
Presentation and discussions about health convergence

Canadian Health System Study Tour
Study of the structure, programs, funding, and other aspects of the Canadian health system

It is very important that international donors, INGOs, and the Burma Government health officials recognize the EHOs, and their knowledge, experience, skill sets, workers, and capacity built up over past 25 years with the funding and technical support of INGOs and international development agencies. Such recognition would greatly enhance the successful convergence of ethnic and Burma Government health systems for the benefit of all the people of Burma and serve as another "Bridge for Peace" in the ongoing peace negotiations.

The health convergence activities of the BPHWT and the other EHOs/HCBOs can be greatly enhanced by INGOs and international donors through:

- Exploring funding opportunities that support health convergence and the peace process (e.g., joint funding for programs in government- and ethnic- controlled areas, cross-border funding, etc.)
- Ensuring that healthcare services and development aid are delivered in alignment with ethnic groups' needs and in a way that supports the peace process
- Considering how planned projects may support program, system, or policy convergence
- Recognizing and supporting ethnic groups as key service providers in the ethnic areas
- Encouraging the involvement of EHOs' leaders in the participation of coordination meetings, workshops, and related activities
- Promoting and directly supporting ethnic and community-based health programs through financial support, capacity building, technical assistance, and supplies

V. Coordination and Cooperation

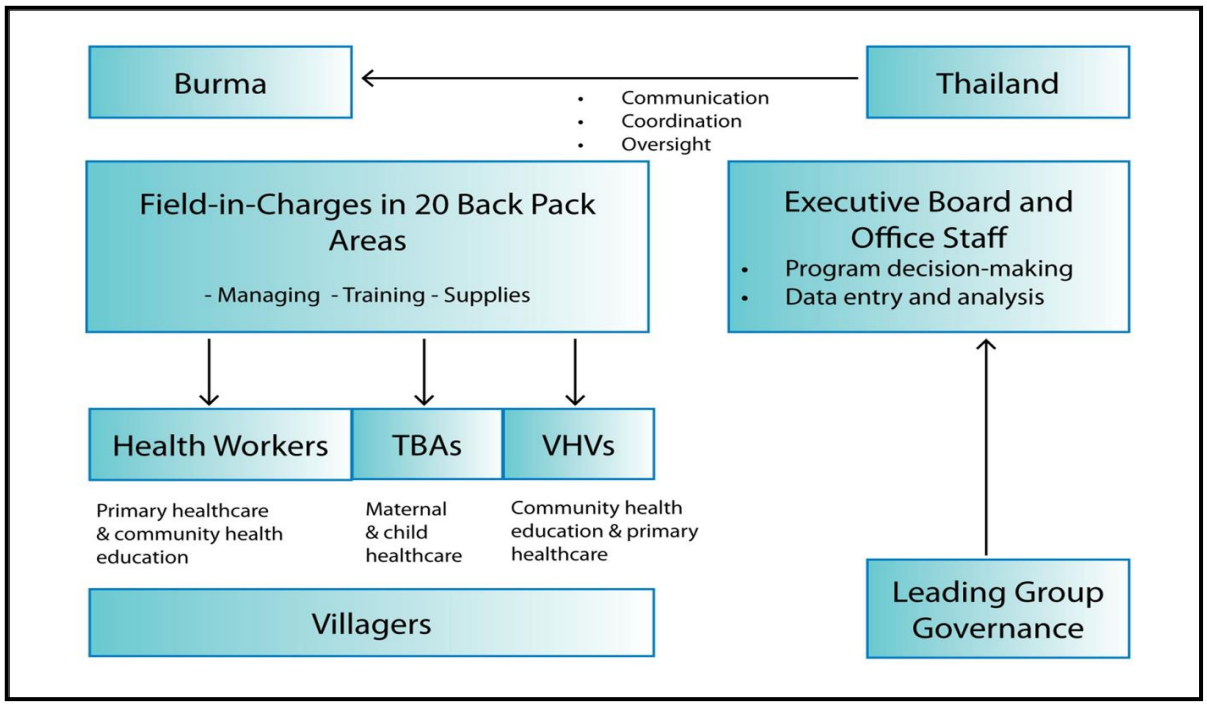
The Back Pack Health Worker Team coordinates with other health organizations, health professionals and health institutions that have the same community health vision. To review the effectiveness of the program, the BPHWT organizes coordination meetings every six months, in conjunction with the regular 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 Rescue Committee (IRC) for medical technical support and organizational capacity building.

The field in-charges from 20 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 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 Border Consortium (TBC) 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. In addition, the Leading Committee members often visit to the targeted field areas and talk to village leaders and communities to see how effective of the programs. The table below summarizes the current Monitoring and Evaluation framework:

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 2015

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**	**2015 EXPECTED RESULTS**	**2015 ACTUAL RESULTS**	**VARIANCES OR DIFFERENCES**	**ASSUMPTION OR RISKS**
Medical Care Program							
1. Provide essential drugs and treat the common diseases	To maintain the existing BPHWT teams	No. of teams existing	Procurement delivery documents; logbooks; analysis of data collected; and field reports	100 BP teams			
	Provide medicine and medical supplies	No. of target population and total case-load (w/m), under/over 5)		200,000 targeted population			It can be more targeted population because of some of the refugees might back to their village according to the current situation
	Treat common diseases and minor injuries	No. of cases treated (w/m, under/over 5)		100,000 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 & annual report	40,000 ITNs will benefit 40,000 HHs			It seems high targeted because BPHWT will collaborate with MARC for this activity.
		Percentage of people in households sleeping under	2016 Impact Assessment Survey	65% of people in households sleeping under ITNs			

		ITNs (Baseline-53%)					
	Provide malaria rapid tests	No. of malaria rapid tests provided	Rapid tests distributing lists	32,400 rapid tests will be provided			
	# of Malaria treated (ACT)	Number of (CASES) women and men diagnosed Pf & Pv malaria with Rapid tests	logbooks; field in-charge reports; midyear and annual report	Women – 4,000 Men - 4530 Total: 8,530 individuals			
		Malaria mortality rates per 1,000 population (baseline-3.5 malaria case deaths per 1000 population)	2016 Impact Assessment Survey	2.2 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)	2016 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%)	2016 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 & over 5)	Delivery document; field reports; exception reports; annual report	-Effective response and treatment for disease outbreaks or emergency situations (w/m & under/over 5			
3. Improve health workers skills and knowledge	Organize Field meetings and workshops	No. of field workshops and meetings	Field meeting and workshop report	Twice a year for 20 areas			
		No. of health workers participated		300 people participate in field workshop and 300 in meeting (15-20 participants in each workshop or meeting)			
	Organized six month regional workshops and meeting	No. of field health workers participated in the program workshop and meeting	Workshop report; mid-year and annual report; workshop attendance list	100 health workers attend six month regional workshops and meeting (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	30 patients referred to clinics or hospitals (w/m) including EMoC cases			- There is no funds support for patient's referral. -Because of the distance the patients might refuse to be referred

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 reports	35,000 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		40,000 children will receive Vitamin A			
2. Educate students and communities about health	Provide school health education	No. of school health sessions and no. of students (w/m)	Field reports; mid-year & annual report	90 sessions attended by 9,000 students (w/m)			
	Organize Village Health Workshops	No. & category of people in Village Health Workshops (w/m)		9,500 people participate in 95 Village Health Workshops			
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	10 VHW trainings for 200 new VHWs (w/m)			
		No. workshop and VHW participate (w/m)		180 VHW workshop for 592 trained VHWs (w/m)			
4. Improve water and sanitation systems in the community to reduce water-borne diseases	Provide water and sanitation systems	No. of latrines built and No. of HHs benefit from latrines	mid - year & annual report	1,500 community latrines or will be benefited 1,500 HHs			
		No. & type of water systems installed	mid - year & annual report	20 gravity flow water systems 1,200 house-holds (6,000			

				pop)			
		No. of HHs and people benefit from water systems (w/m)	mid - year & annual report	35 shallow well systems 400 house-holds (2,000 pop)			
		% of people who own a latrine using latrines (always and sometimes) (Baseline -98%)	2016 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)	2016 Impact Assessment Survey	85% of people who will own a latrine			
Maternal and Child Healthcare Program							
1. Increase maternal and child healthcare	Distribute de-worming medicine	No. of pregnant women receiving de-worming medicine	TBA's form, mid -year & annual report	4,000 pregnant women will receive de-worming medicine			No Vitamin A distributing to postpartum women according to WHO protocol and guideline
	Provide iron prenatally and postnatally to pregnant women	No. of pregnant women and women receiving iron	TBA's form, mid -year & annual report	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 & annual	10 obstetric cases referred			

			report				
	Provide ANC to pregnant women	No. and % of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010)	2016 Impact Assessment Survey	55% 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%)	2016 Impact Assessment Survey	35% 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(Baseline -45% -2010)	2016 Impact Assessment Survey & TBA assessment	55% of TBAs/TTBAs who can Identify at least 5 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines			
2. Raise awareness among villagers on family	Provide family planning supplies	No. of clients receive the family planning supplies (w/m)	Mid - year and annual reports	4,500 people using family planning methods (w/m)			

planning and provide them with family planning supplies	Provide family planning education	% of people using family planning methods	2016 Impact Assessment Survey	35% of people are using family planning methods			Traditional cultural barriers
	Provide family planning pamphlets	No. of pamphlets provided	Distributing list, mid-year & annual report	10,000 family planning pamphlets will be provided			
	Conduct TTBA training	No. of new TTBAs complete the training	mid-year & annual report	6 TTBA training for 240 people (w/m)			
	Conduct TBA/TTBA workshops	No. of TBA/TTBA Follow-up Workshops held & no. of TTBAs attending (w/m)	mid-year & annual report	150 follow-up TBA/TTBA Workshops for 750 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 TBAs/TTBAS % of births attended by health workers (Baseline – TBA -67%, health worker – 27%)	TBA's/TTBA's form; mid-year & annual report 2016 Impact Assessment survey	- 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 attended by health workers			Currently, more TTBAs are trained

		No. of TBA/TTBA kits provided	Kits distributing list; midyear & annual report	1,700 TBAs/TTBAs kits			
		No. of maternity kits provided		5,250 maternity kits			
		Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010, povidine/Iodine or other antiseptic = 354 (85%) -2010	2016 TBA assessment survey	- 85% of new razor blade, sterile scissors, and etc were used - 90% 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	- 90% of postpartum women were given at least 3 information			
4. Provide delivery records	Document deliveries	No. of newborn baby received delivery records	Delivery record issued copies, midyear and annual report	2,000 delivery records			
5. Converge and coordinate with the Burma government's state	Organize Auxiliary Midwife Training and workshop	No. of AMW training provided	AMW training report & attendance list	1 Auxiliary midwife training will be provided			

administered Reproductive healthcare program in Karen State.		No. of AMWs participate in the training		25 AMWs will participate			
		No. of AMW workshop organized	AMW workshop report & attendance list	2 AMW workshops will be organized			
		No. of AMWs participate in the workshop		20 AMWs participate in each workshop			
	Provide AMW kits	No. of AMW kits provided	AMW training report & attendance list	110 kits for 75 AMWs			
	Organize EmOC trainees	No. of EmOC trainees	Mid & annual report	8 EmOC trainnes			
	Provide EmOC supplies	No. of EmOC supplies provided	Mid & annual report	8 EmOC supplies will be provided			
Capacity Building							
1. Improve health worker and staff knowledge and skills	CHW training	No. of trainees completed CHW training (w/m)	CHW training report & attendance list	2 CHW trainings for 70 CHW (w/m)			
	MCH refresher training course	No. of trainees complete training (w/m)	MCH training report &	1 MCH refresher training course for 30 MCH			

			attendance list				
	Public Health Training (CPH)	No. of trainees complete training (w/m)	Training attendance list & report	1 Public Health training for 30 health worker (w/m)			
	Technical refresher training (Malaria & EPI)	No. of trainees complete the training (w/m)	Training attendance list & report	2 Technical refresher training for 60 people (w/m)			IRC
	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 training	No. of participants attend short course training	Mid - year & annual report Attendance list	4 staff members will attend short course training			
	Organize organization development training	No. of participants attend OD training	Attendance list	10 staff members will attend OD training			
	Organize project management training	No. of participants attend project management training	Attendance list	10 staff members will attend project management training			
	Organize internship	No. of participants		60 staff members will attend			

	program			internship program			
2. Promote gender equality in leading positions	Review adopting policies	% 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			It will be held in 2016
Health Information and Documentation							
1. Assess and document community health situation and needs	Produce HID materials	No. of digital cameras and no. of video cameras provided	HID staff report	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 19 areas			
		No. of participants		300 people participate in field workshop and 300 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	10,000 FP pamphlets 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			
	Provide T-shirts	No. of T-shirts provided	Annual report	1,500 T-shirts will be provided			
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	Conduct impact assessment survey	Frequency of impact assessment survey conducted	2016 Impact Assessment survey report	Once every two year			This survey will be conducted in 2016
	Conduct monitoring trip	No. monitoring trips and no of staff	Mid-year & annual report	3 monitoring trips in a year			This can be according to the strategy for organizing the regular meeting
	Conduct six months meeting	No. of health workers attend the six months meeting	Mid-year & annual report	100 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	Office records	12 Executive Board meetings per year			
	Provide staff meetings	No. of staff meetings provided	Office records	24 staff-meetings per year			
Health Convergence							
1. Converge the extensive border-based health system with the Burma government's health system	Standardize curriculum between border-based health CBOs	No. of seminars and meetings No. of participants	Attendance list	Twice in a year			
	Health program convergence between border-based health CBOs and the MOH Burma	No. of seminars and meetings No. of participants No. of field visits	Attendance list	Twice a year			
	Health system convergence between the border-based health CBOs/ EHO and MOH Burma	No. of seminar and meetings No. of participants	Attendance list	Twice a year			
	Organize Auxiliary Midwife Training	No. of AMW training provided No. of AMWs participate in the training	AMW training report & attendance list	1 Auxiliary midwife training will be provided 25 AMWs will participate			

IX. Program Activity Time Lines

ACTIVITIES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Medical Care Program												
1. Maintaining the existing BP teams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Provide medicine and medical supplies			✓	✓				✓	✓			
3. Treat common diseases and minor injuries	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Provide ITNs					✓							
5. Provide malaria rapid tests & medicines	✓											
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. Village health worker training				✓	✓	✓				✓	✓	✓
5. Distributing VHW kits				✓						✓		
6. VHW Workshops				✓						✓		
7. Build community latrines			✓	✓					✓	✓		
8. Install gravity flows & shallow wells			✓	✓					✓	✓		
Maternal and Child Healthcare Program												
1. Distribute 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								√	√	√	√	
13. Provide AMW kits			√	√					√	√		
Capacity Building												
1. Organize community health worker training				√	√	√	√	√	√	√	√	√
1. Organize MCH Refresher Training Courses				√	√	√						
3. Organize public health training			√	√	√	√						
4.Organize technical refresher training		√						√				
5. Attend local and international conferences and trainings					√	√			√	√		
6. Attend local and international short course training					√	√			√	√		
7. Organize organizational development training		√	√				√	√				
8. Organize project management training				√	√					√	√	
9. Organize internship program	√	√	√	√	√	√						
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	**This survey will be conducted in 2016**											
2. Conduct monitoring trips			√	√					√	√		
3. Conduct six monthly regional 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

A. BUDGET Summary

No	Budget Category	Budget Total THAI	Budget Total USD	%
I	Medical Care Program (MCP)	13,609,000	453,633	34%
II	Community Health Education and Prevention Program (CHEPP)	6,817,000	227,233	17%
III	Maternal and Child Health Program (MCHP)	6,213,000	207,100	16%
IV	Capacity Building Program (CBP)	4,846,000	161,533	12%
V	Health Information and Documentation (HID)	649,000	21,633	2%
VI	Program Management and Evaluation	4,342,000	144,733	11%
VII	General Administration	3,524,000	117,467	9%
	TOTAL Budget Summary	**40,000,000**	**1,333,332**	**100%**

B. DETAILS BUDGET

1st January to 31th December 2015 Budget					
Items	**Jan-Jun 2015**	**Jul-Dec 2015**	**Total**	**% by program**	**% total budget**
I. Medical Care Program (MCP)					
A) MCP program operation cost					
1. Program coordinator operation cost (9,000 B x 2 person 6+6 mths)	108,000	108,000	216,000	2%	
2. Program staff operation cost (5000 B x 1 person 6+6 mths)	30,000	30,000	60,000	0%	
MCP program operation cost sub total	**138,000**	**138,000**	**276,000**	**1%**	
B) MCP Activities and supplies					
1. General Medicine & Medical supplies (26,000B x100 BPsx1+1term)	2,600,000	2,600,000	5,200,000	38%	
2. Malaria Medicine & supplies (5,000Bx100 BPsx1+1term)	500,000	500,000	1,000,000	7%	
3. Malaria rapid test (40B x150 x 100BP x1+1term)	600,000	600,000	1,200,000	9%	

4. Mosquito net - ITN(150B x 10,000+10,000 ITN)	1,500,000	1,500,000	3,000,000	22%	
5. Medicine transportation (3,000 B x 100 BPs x 1+1 term)	300,000	300,000	600,000	4%	
6. MCP worker's operation cost (1,200 B x 100 persons 6+6 mths)	720,000	720,000	1,440,000	11%	
7. Field-coordinator operation cost (1500 B x 20 persons 6+6 mths)	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	14,000	14,000	28,000	0%	
11. Log book	15,000	15,000	30,000	0%	
MCP Activities and supplies cost sub total	**6,704,000**	**6,629,000**	**13,333,000**	**99%**	
MCP Sub Total	**6,842,000**	**6,767,000**	**13,609,000**	**100%**	**34.0%**
II. Community Health Education and Prevention Program (CHEPP)					
A) Program Operation Cost					
1. Program coordinator operation cost (9,000 B x 2 persons x 6+6 mths)	108,000	108,000	216,000	3%	
2. Program staff operation cost (5000 B x 1 person x 6+6 mths)	30,000	30,000	60,000	1%	
3. CHEPP Worker's operation cost (1,200 B x 100 persons x 6+6 mths)	720,000	720,000	1,440,000	21%	
4. Field coordinator operation cost (1,500 B x 20 fields x 6+6 mths)	180,000	180,000	360,000	5%	
Program operation cost sub total	***1,038,000***	***1,038,000***	***2,076,000***	**30%**	
B) 1. Village Health Worker Training and Workshop					
1. Village Health Worker Workshop (3,000B x 16 + 16 workshop)	48,000	48,000	96,000	1%	
2. Village Health Worker handbooks (200B x 200 + 200 books)	40,000	40,000	80,000	1%	
3. Village Health Worker Training (100000 B x 2 +3 session)	200,000	300,000	500,000	7%	
4. VHW compensation (1000B x 300 x 1+1 time)	300,000	300,000	600,000	9%	
VHW Training/workshop sub total	***588,000***	***688,000***	***1,276,000***	19%	
C) School Health Promotion				0%	
1. Personal hygiene (20 B x 100 students x 100 BPs)	200,000		200,000	3%	
2. Health Camping event (2,000 B x 100 BPs)		200,000	200,000	3%	
School Health Promotion sub total	**200,000**	**200,000**	**400,000**	6%	
D) Village Health Workshop (3,000 B x 95 + 95 workshop)	**285,000**	**285,000**	***570,000***	8%	
E) Water & Sanitation					
1. Gravity flow water system (40,000 B x10+10 sessions)	400,000	400,000	800,000	12%	
2. Shallow well water system (10,000 B x 20 +15 sessions)	200,000	150,000	350,000	5%	
3. Community Latrine (500B x 750 +750 Latrins)	375,000	375,000	750,000	11%	
Water & Sanitation sub total	***975,000***	***925,000***	***1,900,000***	**28%**	
F) Nutrition Promotion					
1. Vitamin A distribution (3 B x 40,000 + 40,000)	120,000	120,000	240,000	4%	
2.De-worming for mebendazole (1.5 B x 35,000 + 35,000)	52,500	52,500	105,000	2%	
Nutrition promotion sub total	**172,500**	**172,500**	***345,000***	**5%**	
G)Communicable disease Control (Filiariasis)					
1. Final Assessment (50,000 B x 1 term)	50,000		50,000	1%	
2. Awareness workshop 2,000 B x 5 sessions)	10,000	-	10,000	0%	
3. Personal Operation cost (1,500 B x 5 staffs x 6+6 mths)	45,000	45,000	90,000	1%	
Communicable disease Control (Filariasis Pilot Program)sub total	**105,000**	**45,000**	**150,000**	**2%**	

H) IEC materials					
1.VHW curriculum / Hand Book (100B x 1000 Books)	100,000		100,000	1%	
IEC materials sub total	**100,000**	**0**	**100,000**	**1%**	
CHEPP Sub total	***3,463,500***	***3,353,500***	***6,817,000***	***100%***	**17.0%**
III. Maternal and Child Health Program (MCHP)					
A) Program Operation Cost					
1. Program coordinator operation cost (9,000 B x 2 persons x 6+6 mths)	108,000	108,000	216,000	3%	
2. Program staff operation cost (5000 B x 1 person x 6+6 mths)	30,000	30,000	60,000	1%	
3. MCH worker's operation cost (1,200 B x 100 persons x 6+6 mths)	720,000	720,000	1,440,000	23%	
4. Field coordinator operation cost (1,500B x 20 persons x 6+6 mths)	180,000	180,000	360,000	6%	
5. TTBA Curriculum (hand book) 500 books x 70 B	35,000	0	35,000	1%	
6. AMW Stipend (1200 B x 35 person x 1+1 term)	42,000	42,000	84,000	1%	
MCHP program operation cost sub total	***1,115,000***	***1,080,000***	**2,195,000**	35%	
B) TTBA Training (50,000B x 3 + 3 training)	**150,000**	**150,000**	**300,000**	**5%**	
TTBA Training	***150,000***	***150,000***	***300,000***	**5%**	
C) TBA / TTBA Workshop					
1. TBA / TTBA Workshop (9,000 B x 75+ 75 sessions)	675,000	675,000	1,350,000	22%	
2. TBA Kit (400 B x 10 TBAs x 75+75 sessions)	300,000	300,000	600,000	10%	
3. Maternity Kit (150 B x 4 mothers x 10 TBAs x 75+75 sessions)	450,000	450,000	900,000	14%	
4. AMW kits (800B x 35+ 75 kits)	28,000	60,000	88,000	1%	
MCHP Follow-up workshop sub total	***1,453,000***	***1,485,000***	***2,938,000***	**26%**	
D) Obstetrics Gynecologe (OG Instrument) (5000B x 60 sets)	***0***	***300,000***	***300,000***	**5%**	
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 IEC	*50,000*		*50,000*	1%	
Family Planning sub total	***250,000***	***200,000***	***450,000***	**7%**	
MCHP Sub Total	***2,998,000***	***3,215,000***	***6,213,000***	***105%***	**15.5%**
IV. Capacity Building Program (CBP)					
A. Capacity Building					
1. CHW training (400,000 B x 1+1 training)	400,000	400,000	800,000	17%	
2. MCH Refresher Training Course(300,000B x 1 course)		300,000	300,000	6%	
3. Public Health Training (Thammasat University school of Global study & MTC)	350,000		350,000	7%	
4. Auxiliary midwife training (300,000 B x 1session)	300,000		300,000	6%	
5. AMW workshops (25,000Baht x 1 workshop x 1+1 time)	25,000	25,000	50,000	1%	
6.Technical Refresher training (50,000 B x 1+1session)	50,000	50,000	100,000	2%	
7. International Conference and Training	150,000	150,000	300,000	6%	
8. Training monitoring & evaluation	50,000		50,000	1%	
9.Trainner stipend (7,000B x 2 person x 6+6 mths)	84,000	84,000	168,000	3%	
10.Technical Consultant (35,000B x 1person x 6+6 mths)	210,000	210,000	420,000	9%	
11.Organisation Development training (50,000B x 1 term)		50,000	50,000	1%	
12.Project Management Tranining (50,000B x 1 term)	50,000		50,000	1%	

13.Local and international health institution (30,000B x 2 persons x 1+1 time)	60,000	60,000	120,000	2%	
14.Internship Program (1,200B x 20+20 persons x 6+6 mths)	144,000	144,000	288,000	6%	
15.New Training center construction	500,000	1,000,000	1,500,000	31%	
Capacity Building Program sub total	***2,373,000***	***2,473,000***	***4,846,000***	***100%***	**12.1%**
V. Health Information and Documentation (HID)					
A. Health Information & Documentation					
1. Program coordinator operation cost (7,000 B x1personx 6+6mths)	42,000	42,000	84,000	13%	
2. Program staff operation cost (5000B x 1person x 6+6mths)	30,000	30,000	60,000	9%	
3. Still digital camera (4,000 B x 10 + 10 digital cameras)	40,000	40,000	80,000	12%	
4. Photo Development	10,000	10,000	20,000	3%	
5.Video Camera (30,000 x 1 + 1 camera)	30,000	30,000	60,000	9%	
6. Publication (Calendar)	0	70,000	70,000	11%	
7. Publication (T-Shirt 200 x 500)		100,000	100,000	15%	
8. Communication Equipment	35,000	40,000	75,000	12%	
9. Puplication (Poster)		50,000	50,000	8%	
10.Video Documentation	50,000		50,000	8%	
HID Sub total	***237,000***	***412,000***	***649,000***	***100%***	**1.6%**
VI. Program Management and Evaluation					
A) Program managing cost					
1. Leading members Stipend (8,000 B x 5 persons x 6+6 mths)	240,000	240,000	480,000	11%	
2. Director stipend (9,000 B x 1 person x 6+6 mths)	54,000	54,000	108,000	2%	
3. Deputy director stipend (9,000 B x 1 person x 6+6 mths)	54,000	54,000	108,000	2%	
4. Treasurer stipend (9000 B x 1person x 6+6 mths)	54,000	54,000	108,000	2%	
5. Finance manager stipend (9,000 B x 1 person x 6+6 mths)	54,000	54,000	108,000	2%	
6. Accountant stipend (6,500 B x 2 person x 6+6 mths)	78,000	78,000	156,000	4%	
Program managing cost sub total	***534,000***	***534,000***	***1,068,000***	**25%**	
B. Annual and six monthly regional meetingS	**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 1+2 trips)	30,000	60,000	90,000	2%	
Program monitoring and evaluation sub total	***30,000***	***60,000***	***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	***45,000***	***45,000***	***90,000***	**2%**	
b.Health Program Coordination and Development Seminar		***150,000***	**150,000**	**3%**	
G) Impact Assessment Survey Report	**50,000**		**50,000**	**1%**	

Program Management and Evaluation sub total	***2,106,000***	***2,236,000***	***4,342,000***	***100%***	**10.9%**
VII. General Administration					
A. Office running cost					
1. Office running cost (80,000 B x 6+6 mths)	**480,000**	**480,000**	**960,000**	**27%**	
B. Office supplies					
1. Office furniture and Equipments	50,000	50,000	100,000	3%	
2. Computer maintenance	15,000	15,000	30,000	1%	
3. Money Transfer Fees	20,000	20,000	40,000	1%	
4. Car warranty and maintenance	100,000	100,000	200,000	6%	
5. Basic Food for staff members (25,000 B x 6+6 mths)	150,000	150,000	300,000	9%	
Office supplies total	**335,000**	**335,000**	**670,000**	**19%**	
C. Staff stipend					
1. Office staff's stipend (4500 B x 5 persons x 6+6 mths)	135,000	135,000	270,000	8%	
2. Office manager stipend (9,000 x 1person x 6+6 mths)	54,000	54,000	108,000	3%	
3. Driver stipend (5,000B x 2persons x 6+6mths)	60,000	60,000	120,000	3%	
4. Social support	100,000	100,000	200,000	6%	
5. Registration (7,000 B x 15 Persons)	105,000	0	105,000	3%	
6. Intern stipend (1500 B x 10 persons x 6+6 mths)	90,000	90,000	180,000	5%	
Staff stipend total	**544,000**	**439,000**	**983,000**	**28%**	
D. Other Administration					
1. Auditor fee	50,000	0	50,000	1%	
2. Visa Extension Fees (30,000 B x 2+1 persons)	60,000	30,000	90,000	3%	
3. Computer (Desktop/Laptop)(25,000B x 2+1Sets)	50,000	25,000	75,000	2%	
4. Dealing with border committee (5,000B x 6+6 mths)	30,000	30,000	60,000	2%	
5. Distance transportation (15,000 B x 6 + 6 mths)	90,000	90,000	180,000	5%	
6. Emergency Health care	150,000	150,000	300,000	9%	
7. Security cost (3,000 B x 6 + 6 mths)	18,000	18,000	36,000	1%	
8.Local transportation (5,000B x 6+6 mths)	30,000	30,000	60,000	2%	
9. Hpa An training center & Coordination office (5,000Baht x 12 mth)	30,000	30,000	60,000	2%	
Other administration cost total	**508,000**	**403,000**	**911,000**	**26%**	
Total Administration	***1,867,000***	***1,657,000***	**3,524,000**	***100%***	**8.8%**
Grand total for all program in year 2015	**19,886,500**	**20,113,500**	**40,000,000**	**100%**	**100%**